



**National Voluntary  
Consensus Standards  
for Ambulatory Care**

**Part 1**

A  
CONSENSUS  
REPORT

This document includes the foreword, executive summary, and  
the measure specification appendix from the National Quality Forum report  
*National Voluntary Consensus Standards for Ambulatory Care – Part 1.*

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## NATIONAL QUALITY FORUM

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### Foreword

Each year in this country more than a billion visits are made to physician offices and clinics, also known as ambulatory—or outpatient—settings. However, despite the fact that ambulatory settings are the primary locations where patients receive care in the United States, still lacking are agreed-upon quality measures for assessing the performance of outpatient care providers.

Previous National Quality Forum (NQF) reports have addressed performance measures in ambulatory care settings, including, among others, *National Voluntary Consensus Standards for Adult Diabetes Care: 2005 Update*, *Serious Reportable Events in Healthcare – 2006 Update: A Consensus Report*, and *A National Framework for Healthcare Quality Measurement and Reporting: A Consensus Report*.

NQF's "Standardizing Ambulatory Care Performance Measures" project is a multiyear, multistage endeavor that examines ambulatory care settings in a broader context and seeks consensus on standardized measures of outpatient care for performance measurement and reporting. This report presents the work of the project in the following priority areas: asthma/respiratory illness; bone and joint conditions; diabetes; heart disease; hypertension; medication management; mental health and substance use disorders; obesity; prenatal care; prevention, immunization, and screening; and care coordination. It presents 101 NQF-endorsed™ consensus standards that constitute a broad set of performance measures for ambulatory care.

We thank the Standardizing Ambulatory Care Performance Measures Review Committee and its Technical Advisory Panels, as well as NQF Members, for their work with this project and for their collective commitment to improving the quality of ambulatory care.



Janet M. Corrigan, PhD, MBA  
President and Chief Executive Officer

## NATIONAL QUALITY FORUM

# National Voluntary Consensus Standards for Ambulatory Care—Part 1

### Executive Summary

Ambulatory care settings such as physician offices and hospital emergency departments play a critical role in the U.S. healthcare system. With more than a billion visits to physician offices and hospital outpatient and emergency departments taking place each year, ambulatory (outpatient) care embraces a wide range of health conditions, services, and settings—and is the primary site in the United States where patients receive care. However, there is still a lack of agreed-upon quality measures aimed at assessing the performance of outpatient care providers. The National Quality Forum's (NQF's) "Standardizing Ambulatory Care Performance Measures" project is a multistage endeavor that seeks consensus on standardized measures of outpatient care performance measures and reporting.

Phase 1 of NQF's ambulatory care project began in May 2004 and resulted in the identification of 10 priority areas for ambulatory care quality measurement and reporting—heart disease, diabetes, hypertension, obesity, asthma, prevention, depression, medication management, patient experience with care, and coordination of care.

During Phase 2 of the project, NQF addressed an urgent need for physician-focused ambulatory care measures by endorsing a set of consensus standards for ambulatory care that includes 42 consensus measures in 7 priority areas: asthma/respiratory illness, bone conditions, heart disease, hypertension, depression/behavioral health, prenatal care, and prevention (including immunization and screening). The set was included in NQF's report entitled *National Voluntary Consensus Standards for Ambulatory Care: An Initial Physician-Focused Performance Measure Set*, published in late 2005.

Phase 3 of the ambulatory project involves seeking consensus on a broad set of performance measures for ambulatory care in many priority areas. This report presents 101 consensus standards in the following 10 areas: asthma/respiratory illness; bone and joint conditions; diabetes; heart disease; hypertension; medication management; mental health and substance use disorders; obesity; prenatal care; and prevention, immunization, and screening. Categories included in the area of prevention are tobacco cessation, general prevention, screening, and immunization. The report also presents research recommendations for each of these areas.

The project Steering Committee initially identified care coordination as a priority area for measurement. However, the Care Coordination Technical Advisory Panel (TAP) did not recommend any existing measures, because they were either not well developed or did not capture the appropriate characteristics of care coordination. To address this issue and to assist measure developers, the TAP recommended and the Steering Committee accepted a definition and measurement framework for measuring care coordination.

The measure set was developed to improve the quality of ambulatory care through accountability and public reporting and by standardizing quality measurement that describes the practice-level performance in ambulatory care settings. The performance measures presented in the report are suitable for physician practice-level accountability; are derived from all data sources; are fully developed and precisely specified; and are fully open source.

## National Voluntary Consensus Standards for Ambulatory Care—Part 1

PRIORITY AREA	MEASURE
Asthma/Respiratory Illness	<ul style="list-style-type: none"> <li>■ Asthma assessment</li> <li>■ Management plan for people with asthma</li> <li>■ Use of appropriate medications for people with asthma</li> <li>■ Asthma: pharmacologic therapy</li> <li>■ Inappropriate antibiotic treatment for adults with acute bronchitis</li> <li>■ Appropriate treatment for children with upper respiratory infection</li> <li>■ Chronic obstructive pulmonary disease (COPD): assessment of oxygen saturation</li> <li>■ COPD: spirometry evaluation</li> <li>■ COPD: inhaled bronchodilator therapy</li> <li>■ Appropriate testing for children with pharyngitis</li> </ul>
Bone and Joint Conditions	<ul style="list-style-type: none"> <li>■ Osteoarthritis: functional and pain assessment</li> <li>■ Osteoarthritis: assessment for use of anti-inflammatory or analgesic over-the-counter medications</li> <li>■ Low back pain (LBP): use of imaging studies</li> <li>■ LBP: initial assessment</li> <li>■ LBP: physical exam</li> <li>■ LBP: mental health assessment</li> <li>■ LBP: appropriate imaging for acute back pain</li> <li>■ LBP: repeat imaging studies</li> <li>■ LBP: advice for normal activities</li> <li>■ LBP: advice against bed rest</li> <li>■ LBP: recommendations for exercise</li> <li>■ LBP: appropriate use of epidural steroid injections</li> <li>■ LBP: surgical timing</li> <li>■ LBP: patient reassessment</li> <li>■ LBP: shared decisionmaking</li> <li>■ LBP: patient education</li> <li>■ LBP: postsurgical outcomes</li> <li>■ LBP: evaluation of patient experience</li> <li>■ Osteoporosis management in women who had a fracture</li> <li>■ Arthritis: disease modifying antirheumatic drug therapy in rheumatoid arthritis</li> </ul>
Diabetes	<ul style="list-style-type: none"> <li>■ Eye exam</li> <li>■ Foot exam</li> <li>■ Hemoglobin A1c testing</li> <li>■ Hemoglobin A1c management</li> <li>■ Hemoglobin A1c test for pediatric patients</li> <li>■ Blood pressure management</li> <li>■ Urine protein screening</li> <li>■ Lipid profile</li> <li>■ Lipid management: low density lipoprotein cholesterol (LDL-C) &lt;130 and lipid management: LDL-C &lt;100 (measure pair)</li> </ul>
Heart Disease	<ul style="list-style-type: none"> <li>■ Coronary artery disease (CAD): symptom and activity assessment</li> <li>■ CAD: angiotensin converting enzyme (ACE) inhibitor/angiotensin receptor blocker (ARB) therapy</li> <li>■ CAD: antiplatelet therapy</li> <li>■ Ischemic vascular disease (IVD): use of aspirin or another antithrombotic</li> <li>■ CAD—beta blocker therapy: prior myocardial infarction</li> <li>■ Acute myocardial infarction: persistence of beta blocker treatment after a heart attack</li> <li>■ CAD: beta blocker treatment after a heart attack</li> </ul>

(more)

## National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

PRIORITY AREA	MEASURE
Heart Disease (continued)	<ul style="list-style-type: none"> <li>■ IVD: blood pressure control</li> <li>■ CAD: drug therapy for lowering LDL cholesterol</li> <li>■ IVD: complete lipid profile and LDL control &lt;100</li> <li>■ CAD: optimally managed modified risk factors</li> <li>■ Heart failure (HF): assessment of activity level</li> <li>■ HF: assessment of clinical symptoms of volume overload (excess)</li> <li>■ HF: left ventricular function assessment</li> <li>■ HF: ACEI/ARB therapy</li> <li>■ HF: patient education</li> <li>■ HF: beta blocker therapy</li> <li>■ HF: warfarin therapy for patients with atrial fibrillation</li> <li>■ HF: weight measurement</li> </ul>
Hypertension	<ul style="list-style-type: none"> <li>■ Blood pressure (BP) measurement</li> <li>■ Plan of care</li> <li>■ Controlling high BP</li> </ul>
Medication Management	<ul style="list-style-type: none"> <li>■ Documentation of medication list in the outpatient record</li> <li>■ Documentation of allergies and adverse reactions in the outpatient record</li> <li>■ Therapeutic monitoring: annual monitoring for patients on persistent medications</li> <li>■ Drugs to be avoided in the elderly</li> </ul>
Mental Health and Substance Use Disorders	<ul style="list-style-type: none"> <li>■ Major depressive disorder: diagnostic evaluation</li> <li>■ Major depressive disorder: suicide risk assessment</li> <li>■ New episode of depression</li> <li>■ Diagnosis of attention deficit hyperactivity disorder (ADHD) in primary care for school-age children and adolescents</li> <li>■ Management of ADHD in primary care for school-age children and adolescents</li> <li>■ ADHD: follow-up care for children prescribed ADHD medication</li> <li>■ Bipolar disorder and major depression: assessment for manic or hypomanic behaviors</li> <li>■ Bipolar disorder and major depression: appraisal for alcohol or chemical substance use</li> <li>■ Bipolar disorder: appraisal for risk of suicide</li> <li>■ Bipolar disorder: level-of-function evaluation</li> <li>■ Bipolar disorder: assessment for diabetes</li> <li>■ Initiation and engagement of alcohol and other drug dependence treatment</li> </ul>
Obesity	<ul style="list-style-type: none"> <li>■ Body mass index (BMI) in adults &gt;18 years of age</li> <li>■ BMI 2 through 18 years of age</li> </ul>
Prenatal Care	<ul style="list-style-type: none"> <li>■ Screening for Human Immunodeficiency Virus (HIV)</li> <li>■ Anti-D immune globulin</li> <li>■ Blood groups (ABO), D (Rh) type</li> <li>■ Blood group antibody testing</li> </ul>
Prevention, Immunization, and Screening: Tobacco Cessation	<ul style="list-style-type: none"> <li>■ Tobacco use prevention for infants, children, and adolescents and tobacco use cessation for infants, children, and adolescents (measure pair)</li> <li>■ Smoking cessation: medical assistance</li> <li>■ Tobacco use assessment and tobacco cessation intervention (measure pair)</li> </ul>

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**National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

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PRIORITY AREA	MEASURE
Prevention, Immunization, and Screening: General Prevention	<ul style="list-style-type: none"><li>■ Physical activity in older adults</li><li>■ Urinary incontinence management in older adults</li></ul>
Prevention, Immunization, and Screening: Screening	<ul style="list-style-type: none"><li>■ Breast cancer screening</li><li>■ Cervical cancer screening</li><li>■ Chlamydia screening in women</li><li>■ Colorectal cancer screening</li><li>■ Fall risk management in older adults</li><li>■ Osteoporosis testing in older women</li></ul>
Prevention, Immunization, and Screening: Immunization	<ul style="list-style-type: none"><li>■ Childhood immunization status</li><li>■ Flu shots for adults ages 50 to 64</li><li>■ Flu shots for older adults</li><li>■ Influenza immunization</li><li>■ Pneumococcal vaccine needed for all adults aged 65 years or older</li><li>■ Pneumonia vaccination status for older adults</li><li>■ Pneumonia vaccination</li></ul>

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### Appendix A

### Specifications of the NQF-Endorsed Consensus Standards for Ambulatory Care—Part 1

The following table summarizes the detailed specifications for each of the National Quality Forum (NQF)-endorsed™ national voluntary standards for ambulatory care, part 1. All information presented has been derived directly from measure sources/developers without modification or alteration (except when the measure developer agreed to such modification during the NQF Consensus Development Process) and is current as of July 2007.

All NQF-endorsed voluntary consensus standards are open source, meaning they are fully accessible and disclosed.

Issues regarding any NQF-endorsed consensus standards (e.g., modifications to specifications, emerging evidence) may be submitted to NQF for review and consideration via the “Implementation Feedback Form” found at [www.qualityforum.org/implementation\\_feedback.htm](http://www.qualityforum.org/implementation_feedback.htm). NQF will transmit this information to the measure developers and/or compile it for consideration in updating the measure set.

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1

### ASTHMA/RESPIRATORY ILLNESS

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ASTHMA ASSESSMENT</b>	AMA PCP <sup>2,3</sup>	<p>Patients who were evaluated during at least one office visit during the reporting year for the frequency (numeric) of daytime and nocturnal asthma symptoms.*</p> <p>*To be counted in calculations of this measure, symptom frequency must be numerically quantified. Measure may also be met by physician documentation or patient completion of an asthma assessment tool/survey/questionnaire. Assessment tools may include the QualityMetric Asthma Control Test™, NAEPF Asthma Symptoms and Peak Flow Diary.</p> <p>CPT II Code 1005F-Asthma symptoms evaluated.</p>	<p>All patients ages 5-40 years with asthma.</p> <p>Patient selection: ICD-9-CM Codes for asthma: 493.00-493.92 and CPT Codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99254-99255, 99283-99285, 99393-99396, 99401-99404</p> <p>AND</p> <p>Patient's age is between 5 and 40 years.</p>	None.	<p>Paper medical record, paper flowsheet, administrative data using CPT II Codes, and EHRs.</p>

(more)

<sup>1</sup> Intellectual Property (IP) owner. For the most current specifications and supporting information please refer to the IP owner.

#### IP Owners

- AAOS - American Academy of Orthopaedic Surgeons ([www.aaos.org](http://www.aaos.org))
- ACC/AHA - American College of Cardiology/American Heart Association
- Alliance - National Diabetes Quality Improvement Alliance ([www.nationaldiabetesalliance.org](http://www.nationaldiabetesalliance.org))
- AMA PCP - American Medical Association Physician Consortium for Performance Improvement ([www.physicianconsortium.org](http://www.physicianconsortium.org))
- CMS - Centers for Medicare & Medicaid Services ([www.cms.gov](http://www.cms.gov))
- CMS-SCRIPT - The SCRIPT measures were developed by the Coalition for Quality in Medication Use, funded by CMS, and are in the public domain. The project has concluded, and the coalition is no longer available to maintain the measures; however, NCQA has indicated that it will maintain them.
- HealthPartners - ([www.healthpartners.com](http://www.healthpartners.com))
- ICSI - Institute for Clinical Systems Improvement ([www.icsi.org](http://www.icsi.org))
- IPRO - [www.ipro.org](http://www.ipro.org)
- NCQA - National Committee for Quality Assurance ([www.ncqa.org](http://www.ncqa.org))
- NCOA/WC - National Committee for Quality Assurance and Washington Circle ([www.washingtoncircle.org](http://www.washingtoncircle.org))
- NICHQ - National Initiative for Children's Healthcare Quality ([www.nichq.org](http://www.nichq.org))
- NYC-DHMH - New York City Department of Health and Mental Hygiene ([www.nyc.gov/html/doh/html/home.shtml](http://www.nyc.gov/html/doh/html/home.shtml))
- RHI - Resolution Health, Inc. ([www.resolutionhealth.com](http://www.resolutionhealth.com))
- STABLE - STABLE Project is a physician-led quality improvement initiative to develop evidence-based clinical performance measures for bipolar disorder.

<sup>2</sup> AMA and NCQA Notice of Use. Broad public use and dissemination of these measures is encouraged and the measure developers have agreed with NOF that noncommercial uses do not require the consent of the measure developer. Use by health care providers in connection with their own practices is not a commercial use. Commercial use of a measure does require the prior written consent of the measure developer and commercial uses may be subject to a license agreement at the discretion of the measure developer. As used herein, "commercial use" refers to any sale, license, or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed, or distributed for commercial gain, (even if there is no actual charge for inclusion of the measure).

<sup>3</sup> Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement (the Consortium), are intended to facilitate quality improvement activities by physicians. These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures. Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures. THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. CPT® contained in the Measures specifications is copyright 2004 American Medical Association.

<sup>4</sup> LOINC® copyright 2004 Regenstrief Institute, Inc. SNOMED CT® copyright 2004 College of American Pathologists.

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**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>MANAGEMENT PLAN FOR PEOPLE WITH ASTHMA</b>	IPRO	<p>Patients for whom there is documentation, at any time during the abstraction period, that a written asthma management plan was provided either to the patient or the patient's caregiver <i>OR</i> at a minimum, specific written instructions on under what conditions the patient's doctor should be contacted or the patient should go to the emergency room.</p> <p>Inclusions: Copy of asthma management plan on record <i>OR</i> written note by provider documenting having given the patient/parent/caregiver written asthma management instructions.</p> <p>Instructions can include when to use PEFR or change medications in response to a change in patient symptoms and/or when to contact a physician and/or when to go directly to the emergency room.</p>	<p>Patients who had at least two (2) separate ambulatory visits to your practice site for asthma during the time period January through December. A visit is considered an asthma visit if, in any claims-diagnostic field, the patient has an ICD-9-CM Diagnosis Code of 493,XX (i.e., 493 alone or with any extension—the common code combinations are 493,493.0,493.1,493.9; there may be a fifth digit which is either a 0 or 1, e.g., 493.90).</p> <p>If your claims/encounter system also uses CPT Codes-acceptable CPT Codes with these ICD-9-CM Codes are listed below.</p> <p>Acceptable CPT Codes with ICD-9 Codes above include: 99201-99205; 99211-99215; 99241-99245; 99271-99275.</p>	<p>Numerator: Documentation of verbal directions given to patient/parent/caregiver without documentation of written directions being given to patient/parent/caregiver.</p>	Medical record abstraction, identified by administrative data.

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### ASTHMA/RESPIRATORY ILLNESS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA</b>	NCQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> Dispensed at least one prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines during the measurement year.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator:</b> Documentation in the medical record must include, at a minimum, a note indicating the patient received at least one written prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines during the measurement year.</p>	<p><b>Electronic Collection:</b> All patients ages 5-56 years as of December 31 of the measurement year with persistent asthma reported in three age stratifications (5-9, 10-17, 18-56) and as a combined rate. To identify patients with persistent asthma, use all applicable coding schemes listed below (i.e., count patients that meet the criteria for any one of the approaches below. Criteria need not be the same across years).</p> <p>Step 1: Identify patients as having persistent asthma who met at least one of the four criteria below, during <i>both</i> the measurement year and the year prior to the measurement year.</p> <ul style="list-style-type: none"> <li>■ At least one Emergency Department (ED) visit based on CPT Codes: 99281-99285, UB-92 Codes: 045X, 0981 with asthma (ICD-9 Code 493) as the principal diagnosis</li> <li>■ At least one acute inpatient discharge based on CPT Codes: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291 and UB-92 Revenue Codes: 010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 072X, 0987 with asthma ICD-9 Code 493 as the principal diagnosis</li> </ul>	<p>Exclude from the eligible population all patients diagnosed with emphysema and chronic obstructive pulmonary disease (COPD) any time on or prior to December 31 of the measurement year as identified by the following codes, or for medical record collection, as documented within the chart:</p> <p>Emphysema ICD-9 Codes: 492, 506.4, 518.1, 518.2; COPD ICD-9 Codes: 491.2, 493.2, 496, 506.4.</p>	<p>Electronic data (visit and pharmacy encounter data or claims or medical record data).</p>

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<sup>4</sup> This performance measure was developed by and is owned by the National Committee for Quality Assurance ("NCQA"). This performance measure is not a clinical guideline and does not establish a standard of medical care. NCQA makes no representations, warranties or endorsements about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures. NCQA holds a copyright in this measure and can rescind or alter the measure at any time. Users of the measure shall not have the right to alter, enhance, or otherwise modify the measure and shall not disassemble, recompile, or reverse engineer the source code or object code relating to the measure. Anyone desiring to use or reproduce the measure without modification for a noncommercial purpose may do so without obtaining any approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA. © 2004 National Committee for Quality Assurance, all rights reserved.

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA</b> <i>continued</i>			<ul style="list-style-type: none"> <li>■ At least four outpatient asthma visits based on CPT Codes: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99241-99245, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429, 99499; UB-92 Revenue Codes: 051X, 0520, 0521, 0523, 0526, 0527, 0528, 0529, 057X-059X, 077X, 0982, 0983; with asthma; ICD-9 Code 493 as one of the listed diagnoses and at least two asthma medication dispensing events</li> <li>■ At least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions).</li> </ul> <p>Asthma Medications (NCQA will provide a comprehensive list of NDC codes on its web site).</p> <p><i>Preferred therapy:</i></p> <ul style="list-style-type: none"> <li>Cromolyn sodium, inhaled</li> <li>Inhaled corticosteroids</li> <li>Leukotriene modifiers</li> <li>Methylxanthines</li> <li>Nedocromil</li> </ul> <p><i>Add-on therapy:</i></p> <ul style="list-style-type: none"> <li>Long-acting, inhaled beta-2 agonists; short-acting, inhaled beta-2 agonists</li> </ul> <p>Step 2: For a patient identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed, the patient must: meet any one of the other three criteria in step 1, or have at least one diagnosis of asthma in any setting in the same year as the</p>	(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA</b> <i>continued</i>			<p>leukotriene modifier (i.e., measurement year or year prior to the measurement year).</p> <p><b>Medical Record Collection:</b> EHR users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Denominator:</b> All patients ages 5-56 years as of December 31 of the measurement year with persistent asthma reported in three age stratifications (5-9, 10-17, 18-56) and as a combined rate.</p> <p>To identify patients with persistent asthma, use criteria listed below (i.e., count patients that meet the criteria for any one of the approaches below. Criteria need not be the same across years).</p> <p>Step 1: Identify patients as having persistent asthma who met at least one of the four criteria below, during <i>both</i> the measurement year and the year prior to the measurement year.</p> <ul style="list-style-type: none"> <li>■ At least one ED visit with asthma as the principal diagnosis</li> <li>■ At least one acute inpatient discharge with asthma as the principal diagnosis</li> <li>■ At least four outpatient asthma visits with asthma as one of the listed diagnoses and at least two asthma medication prescription/refill events</li> </ul>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA</b> <i>continued</i>			<ul style="list-style-type: none"> <li>■ At least four asthma medication prescription events (i.e., an asthma medication was prescribed/refilled on four occasions).</li> </ul> <p>Asthma Medications (NCQA will provide a comprehensive list of NDC codes on its web site).</p> <p><i>Preferred therapy:</i></p> <ul style="list-style-type: none"> <li>Cromolyn sodium</li> <li>Inhaled corticosteroids</li> <li>Leukotriene modifiers</li> <li>Methylxanthines</li> <li>Nedocromil</li> </ul> <p><i>Add-on therapy:</i></p> <ul style="list-style-type: none"> <li>Long-acting, inhaled beta-2 agonists</li> <li>Short-acting, inhaled beta-2 agonists</li> </ul> <p>Step 2: For a patient identified as having persistent asthma because of at least four asthma medication prescription/refill events, where leukotriene modifiers were the sole asthma medication prescribed, the patient must:</p> <ul style="list-style-type: none"> <li>■ Meet any one of the other three criteria in step 1</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ Have at least one diagnosis of asthma in any setting in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year).</li> </ul> <p><b>Denominator (patients for inclusion):</b> A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified claims (more)</p>		

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA</b> <i>continued</i>			encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.		
<b>ASTHMA: PHARMACOLOGIC THERAPY</b>	AMA PCP <sup>2,3</sup>	Patients who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines) (drug list available) <i>Or</i> CPT II Code 4015F Persistent asthma, preferred long-term control medication, or acceptable alternative treatment, prescribed.	All patients age 5-40 years with mild, moderate, or severe persistent asthma. Patient selection: ICD-9-CM Codes for asthma: 493.00-493.92 <i>And</i> Additional individual medical record review must be completed to identify those patients with mild, moderate, or severe persistent asthma <i>Or</i> CPT II Code 1038F Persistent asthma (mild, moderate or severe) <i>And</i> Patient's age is between 5 and 40 years.	Documentation of patient reason(s) for not prescribing either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment <i>Or</i> CPT II Code w/modifier 4015F 2P.	Paper medical record, paper flowsheet, administrative data using CPT II Codes, and EHRs.

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### ASTHMA/RESPIRATORY ILLNESS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS</b>	NCQA <sup>2,4</sup>	<p>Electronic Collection: A dispensed outpatient prescription for antibiotic medication on or within three days after the Episode Date.</p> <p>Outpatient Antibiotic Medications include:</p> <ul style="list-style-type: none"> <li>Amikacin, Amoxicillin, Amox/Clavulanate, Ampicillin, Ampicillin-sulbactam, Azithromycin, Aztreonam, Benzathine penicillin, Cefaclor, Cefadroxil, Cefadroxil hydrate, Cefazolin, Cefixime, Cefotetan, Cefotixin, Cefdinir, Cefditoren, Cefepime, Cefoperzone, Cefotaxime, Cefpodoxime proxetil, Cefprozil, Ceftrazidime, Ceftriaxone, Ceftrizoxime, Ceftriaxone, Cefuroxime, Cephalexin, Cephadrine, Chloramphenical, Ciprofloxacin, Clarithromycin, Clindamycin, Daptomycin, Dicloxacillin, Doxycycline, Erythromycin, Ery E-Succ/Sulfisoxazole, Fosfomycin, Gatifloxacin, Gentamicin, Gemifloxacin, Kanamycin, Levofloxacin, Lincomycin, Linezolid, Lomefloxacin, Loracarbef, Metronidazole, Moxifloxacin, Minocycline, Nafcillin, Neomycin, Nitrofurantoin, Norfloxacin, Ofloxacin, Oxacillin, Penicillin VK, Penicillin G, Piperacillin, Piperacillin-Tazobactam, Procaine penicillin, Rifampin, Quinupristin/Dalfopristin, Sparfloxacin, Streptomycin, Sulfisoxazole, Sulfdiazine, Sulfamethoxazole, SulfaSalazine, Telithromycin, Tetracycline, Ticarcillin, Ticarcillin-Clavulanate, Trimethoprim, Trimethoprim-sulfamethoxazole, Vancomycin.</li></ul> <p>NCQA will provide a list of NDC codes on its web site.</p>	<p>Electronic Collection:</p> <p>Step 1: Identify all patients 18 years as of January 1 of the year prior to the measurement year to 64 years as of December 31 of the measurement year who during the Intake Period had a claim/encounter with any diagnosis of acute bronchitis and an outpatient visit code. (The Intake Period is between January 1-December 24 of the measurement year.)</p> <p>Codes to identify acute bronchitis: ICD-9-CM Code 466.0</p> <p>Codes to identify outpatient visits: Evaluation and management codes - office or other outpatient services: CPT Codes 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99385, 99386, 99395, 99396, 99401-99404, 99411, 99412, 99420, 99429, 99499</p> <p>Clinic: UB-92 Revenue Code 51X</p> <p>Freestanding clinic: UB-92 Revenue Codes 051X, 0520-0523, 0526-0529, 077X</p> <p>Professional fees, outpatient services: UB-92 Revenue Code 0982</p> <p>Professional fees, clinic: UB-92 Revenue Code 0983</p> <p>Codes to identify ED visits: *</p> <p>UB-92 Bill Codes 13X, AND UB-92 Revenue Codes 045X, 0981 OR CPT Codes 99281-99285</p>	<p>Exclusion for competing diagnoses is built into the denominator specifications.</p> <p>*Exclude from the denominator patients admitted to the hospital from the ED.</p> <p>Step 2: Determine all acute bronchitis Episode Dates. For each patient identified in step 1, determine all outpatient Episode Dates.</p>	<p>Electronic data (visit and pharmacy encounter data or claims or medical record data).</p> <p>(more)</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### ASTHMA/RESPIRATORY ILLNESS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS</b> <i>continued</i>		<p>Medical Record Collection: Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator:</b> Documentation in the medical record must include, at a minimum, a note indicating the patient having received a prescription for antibiotic medications on or within three days after the First Eligible Episode date.</p> <p>Outpatient Antibiotic Medications include: Amikacin, Amoxicillin, Amox/Clavulanate, Ampicillin, Ampicillin-sulbactam, Azithromycin, Aztreonam, Benzathine penicillin, Cefaclor, Cefadroxil, Cefadroxil hydrate, Cefazolin, Cefixime, Cefotetan, Cefotixin, Cefdinir, Cefditoren, Cefepime, Cefoperzone, Cefotaxime, Cefpodoxime proxetil, Cefprozil, Cefazidime, Ceftazidime, Ceftrizoxime, Ceftriaxone, Cefuroxime, Cephalexin, Cephadrine, Chloramphenical, Ciprofloxacin, Clarithromycin, Clindamycin, Daptomycin, Dicloxacillin, Doxycycline, Erythromycin, Ery-E-Succ/Sulfisoxazole, Fosfomycin, Gatifloxacin, Gentamicin, Gemifloxacin, Kanamycin, Levofloxacin, Lincomycin, Linezolid, Lomefloxacin, Loracarbef, Metronidazole, Moxifloxacin, Minocycline, Nafcillin, Neomycin, Nitrofurantoin, Norfloxacin, Ofloxacin, Oxacillin, Penicillin VK, Penicilllin G, Piperacillin, Peperacillin-Tazobactam,</p>	<p>Step 3: Exclude patients who during the 12 months prior to the Episode Date, had at least one claim/encounter with a diagnosis for a comorbid condition. <i>Note:</i> If the acute bronchitis episode occurred on January 1 of the measurement year, look 12 months prior to the start of the measurement year to check for the patient's comorbid condition history.</p> <p>Codes to Identify Comorbid Conditions: HIV infection; HIV asymptomatic: ICD-9-CM Code 042, V Code V08 Cystic fibrosis: ICD-9-CM Code 277.0 Disorders of the immune system: ICD-9 CM Code 279</p> <p>Malignancy neoplasms: ICD-9-CM Code 140-208 Chronic bronchitis: ICD-9-CM Code 491 Emphysema: ICD-9-CM Code 492 Bronchiectasis: ICD-9-CM Code 494 Extrinsic allergic alveolitis: ICD-9-CM Code 495 Chronic airway pulmonary obstruction, not otherwise classified: ICD-9-CM Codes 496, 493.2 Pneumoconiosis and other lung disease due to external agents: ICD-9-CM Codes 500-508 Other diseases of the respiratory system: ICD-9-CM Codes 510-519 Tuberculosis: ICD-9-CM Codes 010-018.</p> <p>Step 4: Test for negative medication history. Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or which was active on the Episode Date.</p>	(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS</b> <i>continued</i>		Procaine penicillin, Rifampin, Quinupristin/Dalfopristin, Sparfloxacin, Streptomycin, Sulfisoxazole, Sulfdiazine, Sulfamethoxazole, Sulfaalazine, Telithromycin, Tetracycline, Ticarcillin, Ticarcillin-Clavulanate, Trimethoprim, Trimethoprim-sulfamethoxazole, Vancomycin.	Outpatient Antibiotic Medications include: Amikacin, Amoxicillin, Amox/Clavulanate, Ampicillin, Ampicillin-sulbactam, Azithromycin, Aztreonam, Benzathine penicillin, Cefaclor, Cefadroxil, Cefadroxil hydrate, Cefazolin, Cefixime, Cefotetan, Cefoxitin, Cefdinir, Cefditoren, Cefepime, Cefoperzone, Cefotaxime, Cefpodoxime proxetil, Cefprozil, Cefazidime, Cefthufen, Ceftizoxime, Ceftriaxone, Cefuroxime, Cephalexin, Cephadrine, Chloramphenical, Ciprofloxacin, Clarithromycin, Clindamycin, Daptomycin, Dicloxacillin, Doxycycline, Erythromycin, Ery E-Succ/Sulfisoxazole, Fosfomycin, Gatifloxacin, Gentamicin, Gemifloxacin, Kanamycin, Levofloxacin, Lincomycin, Linezolid, Lomefloxacin, Loracarbef, Metronidazole, Moxifloxacin, Minocycline, Naftilin, Neomycin, Nitrofurantoin, Norfloxacin, Ofloxacin, Oxacillin, Penicillin VK, Penicillin G, Piperacillin, Piperacillin-Tazobactam, Procaine penicillin, Rifampin, Quinupristin/Dalfopristin, Sparfloxacin, Streptomycin, Sulfisoxazole, Sulfdiazine, Sulfamethoxazole, Sulfaalazine, Telithromycin, Tetracycline, Ticarcillin, Ticarcillin-Clavulanate, Trimethoprim, Trimethoprim-sulfamethoxazole, Vancomycin. <i>Note:</i> If the acute bronchitis episode occurred on January 1 of the measurement year, look 30 days prior to the start of the measurement year to check for the patient's negative medication history. (Please refer to the NQF web site for a comprehensive list of NDC codes for antibiotic medications.)		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS</b> <i>continued</i>			<p>Step 5: Test for Competing Diagnoses. Exclude Episode Dates where there is a claim or encounter with a competing diagnosis 30 days prior to the Episode Date through 7 days after the Episode Date.</p> <p><i>Note:</i> If the episode occurred on January 1 of the measurement year, look 30 days prior to the start of the measurement year to check for the patient's competing diagnosis history.</p> <p>Codes to identify Competing Diagnoses: Intestinal infections: ICD-9-CM Codes (001-009) Pertussis: ICD-9-CM (033)</p> <p>Bacterial infection unspecified: ICD-9-CM (041.9)</p> <p>Lyme disease and other arthropod-borne diseases: ICD-9-CM (088)</p> <p>Otitis media: ICD-9-CM (382)</p> <p>Acute sinusitis: ICD-9-CM (461)</p> <p>Acute pharyngitis: ICD-9-CM (462, 034.0)</p> <p>Acute tonsillitis: ICD-9-CM (463)</p> <p>Chronic sinusitis: ICD-9-CM (473)</p> <p>Infections of the pharynx, larynx, tonsils, adenoids: ICD-9-CM (464.1-464.3, 474, 478.21, 478.22, 478.24, 478.29, 478.71, 478.79, 478.9)</p> <p>Prostatitis: ICD-9-CM (601)</p> <p>Celullitis, mastoiditis, other bone infections: ICD-9-CM (681, 682, 730, 383)</p> <p>Acute lymphadenitis: ICD-9-CM (683)</p> <p>Impetigo: ICD-9-CM (684)</p> <p>Skin staph infections: ICD-9-CM (686)</p> <p>(more)</p>		

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS</b> <i>continued</i>			<p>Pneumonia: ICD-9-CM (481-486)            Gonococcal infections and venereal diseases:            ICD-9-CM (098, 099) V Codes (W01.6, V02.7, V02.8)            Syphilis: ICD-9-CM (090-097)            Chlamydia: ICD-9-CM (078.88, 079.88, 079.98)            Inflammatory diseases: (female reproductive organs): ICD-9-CM (614- 616)            Infections of the kidney: ICD-9-CM (590)            Cystitis or UT: ICD-9-CM (595, 599.0).</p> <p>Step 6: Calculate Measure Denominator. This measure examines one Eligible Episode per patient. Select the First Eligible Episode for each patient during the measurement Intake Period that meets all criteria for inclusion in the denominator. This is the patient's First Eligible Episode.</p> <p><b>Medical Record Collection:</b> EHR users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p>Step 1: Identify all patients 18 years as of January 1 of the year prior to the measurement year to 64 years as of December 31 of the measurement year who during the Intake Period had an outpatient diagnosis of acute bronchitis. (The Intake Period is between January 1-December 24 of the measurement year.)</p>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS</b> <i>continued</i>			<p>ED visits that do not result in a hospital admission are considered an outpatient visit for this measure.</p> <p>Exclude from the denominator patients admitted to the hospital from the ED.</p> <p>Step 2: Determine all acute bronchitis Episode Dates. For each patient identified in step 1, determine all outpatient Episode Dates.</p> <p>Step 3: Exclude patients who during the 12 months prior to the Episode Date had at least one diagnosis for a comorbid condition.</p> <p><i>Note:</i> If the acute bronchitis episode occurred on January 1 of the measurement year, look 12 months prior to the start of the measurement year to check for the patient's comorbid condition history.</p> <p>Comorbid conditions: HIV infection; HIV asymptomatic; cystic fibrosis; disorders of the immune system; malignancy neoplasms; chronic bronchitis; emphysema; bronchiectasis; extrinsic allergic alveolitis; chronic airway pulmonary obstruction, not otherwise classified; pneumonocrosis and other lung disease due to external agents; other diseases of the respiratory system; tuberculosis.</p> <p>Step 4: Test for negative medication history.</p> <p>Exclude Episode Dates where a new or refill prescription for an antibiotic medication was written 30 days prior to the Episode Date or which was active on the Episode Date.</p> <p>Outpatient Antibiotic Medications include: Amikacin, Amoxicillin, Amox/Clavulanate, Ampicillin, Ampicillin-sulbactam, Azithromycin,</p>	(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS</b> <i>continued</i>			Aztreonam, Benzathine penicillin, Cefaclor, Cefadroxil, Cefadroxil hydrate, Cefazolin, Cefotetan, Cefoxitin, Cefdinir, Cefditoren, Cefepime, Cefixime, Cefoperzone, Cefotaxime, Cefpodoxime proxetil, Cefprozil, Ceftrazidime, Ceftriaxone, Ceftrizoxime, Ceftriaxone, Cefuroxime, Cephalexin, Cephadrine, Chloramphenical, Ciprofloxacin, Clarithromycin, Clindamycin, Daptomycin, Dicloxacillin, Doxycycline, Erythromycin, Ery F-Succ/Sulfisoxazole, Fosfomycin, Gatifloxacin, Gentamicin, Gemifloxacin, Kanamycin, Levofloxacin, Lincomycin, Linezolid, Lomefloxacin, Loracarbef, Metronidazole, Moxifloxacin, Minocycline, Naftcilin, Neomycin, Nitrofurantoin, Norfloxacin, Ofloxacin, Oxacillin, Penicillin VK, Penicillin G, Piperacillin, Piperacillin-Tazobactam, Procaine penicillin, Rifampin, Quinupristin/Dalfopristin, Sparfloxacin, Streptomyacin, Sulfafoxazole, Sulfadiazine, Sulfamethoxazole, SulfaSalzine, Telithromycin, Tetracycline, Ticarcillin, Ticarcillin-Clavulanate, Trimethoprim, Trimethoprim-sulfamethoxazole, Vancomycin.	<i>Note:</i> If the acute bronchitis episode occurred on January 1 of the measurement year, look 30 days prior to the start of the measurement year to check for the patient's negative medication history. <i>Step 5: Test for Competing Diagnoses. Exclude Episode Dates where there is a competing diagnosis 30 days prior to the episode date through 7 days after the Episode Date.</i> <i>Note:</i> If the episode occurred on January 1 of the measurement year, look 30 days prior to the start of the measurement year to check for the patient's competing diagnosis history.	(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ADULTS WITH ACUTE BRONCHITIS</b> <i>continued</i>			<p>Competing Diagnoses: Intestinal infections; pertussis; bacterial infection unspecified; Lyme disease and other arthropod-borne diseases; otitis media; acute sinusitis; acute pharyngitis; acute tonsillitis; chronic sinusitis; infections of the pharynx, larynx, tonsils, adenoids; prostatitis; cellulitis, mastoiditis, other bone infections; acute lymphadenitis; impetigo; skin staph infections; pneumonia; gonococcal infections and venereal diseases; syphilis; chlamydia; inflammatory diseases (female reproductive organs); infections of the kidney; cystitis.</p> <p>Step 6. Calculate Measure Denominator. This measure examines one Eligible Episode per patient. Select the First Eligible Episode for each patient during the measurement Intake Period that meets all criteria for inclusion in the denominator. This is the patient's First Eligible Episode.</p> <p>A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior 12 months from which a purposeful sample (random, consecutive retrospective, or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p>		(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### ASTHMA/RESPIRATORY ILLNESS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION</b>	NCQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> Numerator: A dispensed prescription for antibiotic medication on or within three days after the Episode Date. The measure examines one Eligible Episode per patient.</p> <p>Antibiotic Medications (NCQA) will provide a list of NDC codes for antibiotic medications on its web site: Amoxicillin, Amox/Clavulahate, Ampicillin, Azithromycin, Cefadroxil, Cefadroxil hydrate, Cefazolin, Cefdinir, Cefixime, Cefditoren, Ceftriaxone, Cefpodoxime proxetil, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, Cephadrine, Ciprofloxacin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Ery-E-Succ/Sulfisoxazole, Gatifloxacin, Levofloxacin, Lomefloxacin, Loracarbef, Minocycline, Ofloxacin, Penicillin VK, Penicillin G, Sparfloxacin, Sulfisoxazole, Tetracycline, Trimethoprim, Trimethoprim-sulfamethoxazole.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator:</b> Documentation in the medical record must include, at a minimum, a note indicating a written prescription for antibiotic medication (drug list available) on the Episode Date. The measure examines one Eligible Episode per patient.</p>	<p><b>Electronic Collection:</b> Denominator: Step 1: Identify all children age 3 months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year who had an outpatient visit with only a diagnosis of non-specific URI and an outpatient visit code.</p> <p>Codes to identify URI: Acute nasopharyngitis (common cold): 460 URL unspecified site: 465. Codes to identify outpatient visits: Evaluation and management codes-office or other outpatient service, CPI: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99381-99385, 99391-99395, 99401-99404, 99411, 99412, 99420, 99429, 99499 - Clinic UB-92: 051X Freestanding clinic UB-92: 0520-0523, 0526-0529, 077X, 052X Professional fees-outpatient services UB-92: 0982 Professional fees-clinic UB-92: 0983 Codes to identify ED visits*</p> <p>UB-92 Type of Bill Codes: 13X, and UB-92 Revenue Codes: 045X 0459, 0981 or CPT Code: 99281-99285 *Exclude from the denominator patients admitted to the hospital from the ED.</p> <p>Step 2: For each patient identified in step 1, determine all outpatient Episode Dates.</p> <p>Step 3: Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or which was active on the Episode Date.</p>	<p>None.</p>	Electronic data (visit and pharmacy encounter data or claims or medical record data).

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION</b> <i>continued</i>			<p>Antibiotic Medications: Amoxicillin, Amox/Clavulanate, Ampicillin, Azithromycin, Cefadroxil hydrate, Cefazolin, Cefdinir, Cefixime, Cefditoren, Cefixime, Cefpodoxime proxetil, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, Cephadrine, Ciprofloxacin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Ery F-Succ/Sulfisoxazole, Lomefloxacin, Gatifloxacin, Levofloxacin, Loracarbef, Minocycline, Ofloxacin, Penicillin VK, Penicillin G, Sparfloxacin, Sulfisoxazole, Tetracycline, Trimethoprim, Trimethoprim-sulfamethoxazol.</p> <p><i>Note:</i> If the episode occurred on July 1 of the year prior to the measurement year, look 30 days prior to the start of the Intake Period (June 1-30) to check for negative medication history.</p> <p>Step 4: This measure examines one eligible episode per patient. Select the First Eligible Episode for each patient during the measurement intake period that meets all criteria for inclusion in the denominator.</p> <p><b>Medical Record Collection:</b> EHR users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION</b> <i>continued</i>			<p>Step 1: Identify all children age 3 months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year who had an outpatient visit with only a diagnosis of non-specific upper respiratory infection (acute nasopharyngitis (common cold) or URI unspecified site).</p> <p>Step 2: For each patient identified in step 1, determine all outpatient Episode Dates.</p> <p>Step 3: Exclude Episode Dates where a new or refill prescription for an antibiotic medication was written 30 days prior to the Episode Date or which was active on the Episode Date.</p> <p>Antibiotic Medications: Amoxicillin, Amox/Clavulanate, Ampicillin, Azithromycin, Cefadroxil hydrate, Cefazolin, Cefdinir, Cefixime, Cefditoren, Ceftriaxone, Cefpodoxime proxetil, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, Cephadrine, Ciprofloxacin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Ery E-Succ/Sulfisoxazole, Gatifloxacin, Levofloxacin, Lomefloxacin, Loracarbef, Minocycline, Ofloxacin, Penicillin VK, Penicillin G, Sparfloxacin, Sulfisoxazole, Tetracycline, Trimethoprim, Trimethoprim-sulfamethoxazole.</p> <p>Note: If the episode occurred on July 1 of the year prior to the measurement year, look 30 days prior to the start of the Intake Period (June 1-30) to check for negative medication history.</p>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION</b> <i>continued</i>			<p>Step 4: This measure examines one Eligible Episode per patient. Select the First Eligible Episode for each patient during the measurement intake Period that meets all criteria for inclusion in the denominator.</p> <p>Denominator (patients for inclusion): A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD); ASSESSMENT OF OXYGEN SATURATION</b>	AMA PCP <sup>2,3</sup>	<p>Patients with oxygen saturation assessed and documented.</p> <p>CPT Codes for oxygen saturation: 94760, 94761, 82803, 82805, 82810 or LOINC Codes for oxygen saturation: 11556-8, 2704-5, 2710-2, 19211-2, 2705-2, 3148-4, 3149-2, 34163-6, 19218-7, 19219-5, 19221-1, 19220-3, 20564-1, 2708-6, 2709-4, 19224-5, 2711-0, 2714-4, 2715-1, 2716-9, 2717-7, 24336-0, 24337-8, 24338-6, 24339-4, 24341-0, 24342-8, 24343-6, 24344-4</p> <p>OR</p> <p>CPT II Code: 3028F - Oxygen saturation results documented and reviewed (includes assessment through pulse oximetry or arterial blood gas measurement).</p>	<p>All patients aged <math>\geq 18</math> years with the diagnosis of COPD and a functional expiratory volume (FEV<sub>1</sub>) &lt;40 % of predicted value.</p> <p>Patient selection: Documentation in the medical record of a diagnosis of COPD</p> <p>OR</p> <p>ICD-9-CM Codes for COPD: 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496 AND</p> <p>OR</p> <p>CPT Codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404</p> <p>AND</p> <p>Documentation in the medical record of a FEV<sub>1</sub> &lt;40% of predicted value</p> <p>OR</p> <p>CPT II Codes: 3040F FEV<sub>1</sub> &lt;40% of predicted value; 3022F FEV<sub>1</sub> <math>\geq</math>40% of predicted value</p> <p>AND</p> <p>Patient's age is <math>\geq 18</math> years of age.</p>	<p>Documentation of medical reason(s) for not assessing oxygen saturation (equipment not available, other medical reason)</p> <p>OR</p> <p>CPT II Code w/modifier: 3028F 1P</p> <p>Documentation of patient reason(s) for not assessing oxygen saturation (economic, social, religious, other patient reasons)</p> <p>OR</p> <p>CPT II Code w/modifier: 3028F 2P</p> <p>Documentation of system reason(s) for not assessing oxygen saturation</p> <p>OR</p> <p>CPT II Code w/modifier: 3028F 3P.</p>	<p>Paper medical record, paper flowsheet, administrative data using CPT II Codes, and EHRs.</p>

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CHRONIC OBSTRUCTIVE PULMONARY DISORDER: SPIROMETRY EVALUATION</b>	AMA PCP <sup>2,3</sup>	Patients with spiroometry results documented (FEV <sub>1</sub> and FEV <sub>1</sub> /FVC). CPT Codes for spiroometry: 94010, 94014, 94015, 94016, 94060, 94070, 94620 <i>Or</i> CPT II Code 3023F: Spirometry results documented and reviewed.	All patients aged ≥18 years with the diagnosis of COPD. Patient selection: Documentation in the medical record of a diagnosis of COPD <i>Or</i> ICD-9-CM Codes for COPD: 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496 <i>And</i> Patient's age is ≥18 years of age.	Documentation of medical reason(s) for no spiroometry evaluation (patient physically unable to perform spirometry, other medical reasons) <i>Or</i> CPT II Code w/modifier: 3023F 1P. Documentation of patient reason(s) for no spirometry evaluation (patient refusal, other patient reasons) <i>Or</i> CPT II Code w/modifier: 3023F 2P. Documentation of system reason(s) for no spirometry evaluation <i>Or</i> CPT II Code w/modifier: 3023F 3P.	Paper medical record, paper flowsheet, administrative data using CPT II Codes, and EHRs.
<b>CHRONIC OBSTRUCTIVE PULMONARY DISORDER: INHALED BRONCHODILATOR THERAPY</b>	AMA PCP <sup>2,3</sup>	Symptomatic patients who were prescribed an inhaled bronchodilator (β <sub>2</sub> -agonist and/or anticholinergic; drug list available). <i>Or</i> CPT II Code: 4025F Inhaled bronchodilator prescribed.	All patients aged ≥18 years with the diagnosis of COPD who have FEV <sub>1</sub> /FVC <70% and have symptoms. Patient selection: Documentation in the medical record of a diagnosis of COPD <i>Or</i> ICD-9-CM Codes for COPD: 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496 <i>And</i> CPT codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99383-99385, 99393-99395, 99401-99404 <i>And</i> Documentation in the medical record of FEV <sub>1</sub> /FVC <70%	Documentation of medical reason(s) for not prescribing an inhaled bronchodilator (allergy, drug interaction, contraindication, other medical reasons) <i>Or</i> CPT II Code w/modifier: 4025F 1P. Documentation of patient reason(s) for not prescribing an inhaled bronchodilator (economic, social, religious, other patient reasons) <i>Or</i> CPT II Code w/modifier: 4025F 2P. Documentation of system reason(s) for not prescribing an inhaled bronchodilator <i>Or</i> CPT II Code w/modifier: 4025F 3P.	Paper medical record, paper flowsheet, administrative data using CPT II Codes, and EHRs.  (more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
CHRONIC OBSTRUCTIVE PULMONARY DISORDER: INHALED BRONCHODILATOR THERAPY <i>continued</i>			<p>AND</p> <p>Documentation in the medical record of COPD symptoms (synonyms available). There must be documentation of the presence of at least one of the following: dyspnea, cough/sputum, or wheezing</p> <p>OR</p> <p>CPT II Codes: 3025F Spirometry test results demonstrate FEV<sub>1</sub>/FVC &lt;70% with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing); 3027F Spirometry test results demonstrate FEV<sub>1</sub>/FVC ≥70%, or patient does not have COPD symptoms)</p> <p>OR</p> <p>ICD-9 Codes for dyspnea: 786.00, 786.01, 786.02, 786.05, 786.06, 786.09, 493.2</p> <p>OR</p> <p>ICD-9 Codes for cough: 786.2, 491.0</p> <p>OR</p> <p>ICD-9 Codes for sputum: 786.3, 786.4</p> <p>OR</p> <p>ICD-9 Codes for wheezing: 786.07</p> <p>AND</p> <p>Patient's age is ≥18 years of age.</p> <p>Note: Documentation of FEV<sub>1</sub>/FVC and COPD symptoms do not have to occur during the same office visit.</p>	(more)	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### ASTHMA/RESPIRATORY ILLNESS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS</b>	NCQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> A strep test administered in the seven-day period from three days prior through three days after the First Eligible Episode Date.</p> <p>Codes to identify Group A Streptococcus Tests, antigen detection by enzyme immunoassay, CPT (87430) LOINC (6556-5, 6557-3, 6558-1, 6559-9, 18481-2, 31971-5), by nucleic acid CPT (87650-87652) LOINC (5036-9), by direct optical observation CPT (87880), by throat culture CPT (8781, 87070-87071) LOINC (626-2, 11268-0, 11475-1, 17656-0).</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample. Documentation in the medical record must include at minimum, a note indicating a strep test was administered in the seven-day period from three days prior through three days after the First Eligible Episode Date. Group A Streptococcus Tests include antigen detection by enzyme immunoassay, nucleic acid, by direct optical observation, or by throat culture.</p>	<p><b>Electronic Collection:</b></p> <p>Step 1: Identify children age 2 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year who had an outpatient visit with only a diagnosis of pharyngitis. Exclude claims/encounters with more than one diagnosis.</p> <p>ICD-9-CM Codes to identify Pharyngitis: 462</p> <p>Acute or unspecified pharyngitis: 462</p> <p>Acute tonsillitis: 463</p> <p>Streptococcal tonsillitis: 034.0</p> <p>CPT Codes to identify outpatient visits: Evaluation and management codes-office or other outpatient services: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99382-99385, 99392-99395 99401-99404, 99411, 99412, 99420, 99429, 99499 UB-92 Codes to identify outpatient visits:</p> <p>Clinic: 051X</p> <p>Freestanding clinic: 0520-0523, 0526-0529, 077X</p> <p>Professional fees-outpatient services: 0982</p> <p>Professional fees-clinic 0983</p> <p>Codes to identify ED visits:<sup>*</sup></p> <p>UB-92 Type of Bill Codes: 13X and UB-92</p> <p>Revenue Codes: 045X, 0981 or CPT Codes 99281-99285.</p>	<p>None.</p>	<p>Electronic data (visit and pharmacy encounter data or claims or medical record data).</p>

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS</b> <i>continued</i>			<p>Step 3: For each Episode Date with a qualifying diagnosis, determine if antibiotics were prescribed on or within three days after the Episode Date. Exclude Episode Date if the patient did not receive antibiotics on or within three days after the Episode Date.</p> <p>Antibiotic Medications (NCQA will provide a list of NDC codes for antibiotic medications on its web site): Amoxicillin, Amox/Clavulanate, Ampicillin, Azithromycin, Cefadz, Cefadroxil hydrate, Cefazoline, Cefdinir, Cefixime, Cefitoren, Cefibutene, Cefpodoxime proxetil, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, Cephalidine, Ciprofloxacin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Ery E-Succ/Sulfisoxazole, Gatifloxacin, Levofloxacin, Lomefloxacin, Loracarbef, Minocycline, Ofloxacin, Penicillin VK, Penicillin G, Sparfloxacin, Sulfisoxazole, Tetracycline, Trimethoprim, Trimethoprim-sulfamethoxazole.</p> <p>Step 4: Exclude Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Dates or which was active on the Episode Dates.</p> <p><i>Note:</i> If the episode occurred on July 1 of the year prior to the measurement year, look-back 30 days prior to the start of the Intake Period (i.e., June 1-30) to check for the patient's medication history.</p> <p>Step 5: The measure examines one Eligible Episode per patient. When calculating the final measure denominator, select the First Eligible Episode for each patient during the measurement Intake Period that meets all criteria for inclusion in the denominator.</p>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS</b> <i>continued</i>			<p>Medical Record Collection: EHR users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p>Step 1: Identify children age 2 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year who had an outpatient visit with only a diagnosis of pharyngitis (acute or unspecified pharyngitis, acute tonsillitis or streptococcal tonsillitis). Exclude encounters with more than one diagnosis.</p> <p>Step 2: For each patient identified in step 1, determine all outpatient Episode Dates.</p> <p>Step 3: For each Episode Date with a qualified diagnosis, determine if antibiotics were prescribed on or within three days after the Episode Dates. Exclude Episode Date if the patient did not receive antibiotics on or within three days after the Episode Date.</p> <p>Antibiotic Medications (NCQA will provide a list of NDC codes for antibiotic medications on its web site): Amoxicillin, Amox/Clavulanate, Ampicillin, Azithromycin, Cefadroxil, Cefadroxil hydrate, Cefazolin, Cefdinir, Cefixime, Cefditoren, Cefixime, Cefpodoxime proxetil, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, Cephadrine, Ciprofloxacin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Ery F-Succ/Sulfisoxazole, Gatifloxacin, Levofloxacin, Lomefloxacin, Loracarbef, (more)</p>		

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**ASTHMA/RESPIRATORY ILLNESS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS</b> <i>continued</i>			<p>Minocycline, Ofloxacin, Penicillin VK, Penicillin G, Sparfloxacin, Sulfisoxazole, Tetracycline, Trimethoprim, Trimethoprim-sulfamethoxazole.</p> <p>Step 4: Exclude episode dates where a new or refill prescription for an antibiotic medication was written 30 days prior to the Episode Date or which was active on the Episode Date.</p> <p>Step 5: The measure examines one Eligible Episode per patient. When calculating the final measure denominator, select the First Eligible Episode for each patient during the measurement intake period that meets all criteria for inclusion in the denominator.</p> <p><b>Denominator (patients for inclusion):</b> A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective, or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p>		(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>OSTEOPHYSIS: FUNCTIONAL AND PAIN ASSESSMENT</b>	AMA PCP <sup>2,3</sup> / AAOS	Patient visits with assessment for function and pain documented.  Medical record must include: Documentation of the patient's satisfaction or dissatisfaction with function and pain  OR Documentation of the use of a standardized scale or completion of an assessment questionnaire (e.g., SF-36, AAOS Hip & Knee Questionnaire)  OR CPT II Code: 1006F Osteoarthritis symptoms and functional status assessed.	All visits for patients with OA ≥21 years of age:  Patient selection: ICD-9-CM Codes for OA: 715.00-715.98 AND CPT Codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 AND Patient's age is ≥21 years.	None.	EHRS, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.
<b>OSTEOPHYSIS: ASSESSMENT FOR USE OF ANTI- INFLAMMATORY OR ANALGESIC OVER-THE- COUNTER MEDICATIONS</b>	AMA PCP <sup>2,3</sup> / AAOS	Patient visits with assessment for use of anti-inflammatory or analgesic OTC medications documented (drug list is available).  Assessment may include: documentation of current medications, continue same medications, change in medication dose, documentation indicating that the patient was asked about OTC medication use  OR CPT II Code: 1007F Use of anti-inflammatory or analgesic OTC medications assessed.	All visits for patients with OA ≥21 years of age:  Patient selection: ICD-9-CM Codes for OA: 715.00-715.98 AND CPT Codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 AND Patient's age is ≥21 years.	None.	EHRS, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>LOW BACK PAIN (LBP): USE OF IMAGING STUDIES</b>	NCQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> Patients who received an imaging study (plain x-ray, MRI, CT scan) conducted on the Episode Start Date or in the 28 days following the Episode Start Date.</p> <p>Codes to identify imaging studies for LBP (only if they appear in conjunction with an applicable low back pain diagnosis—see denominator for codes).</p> <p>Radiologic examination: CPT Codes: 72010, 72020, 72052, 72100, 72110, 72120, 72200, 72202, 72220; UB-92 Revenue Codes: 320, 329.</p> <p>Computed tomography: CPT Codes: 72131, 72133; UB-92 Revenue Codes: 350, 352, 359.</p> <p>Magnet resonance imaging: CPT Codes: 72141, 72142, 72146, 72149, 72156, 72158; UB-92 Revenue Codes: 610, 612, 614, 619</p> <p>Professional fees: UB-92 Revenue Code: 972.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator:</b> Medical Record Collection: Patients with documentation of an imaging study (plain x-ray, MRI, CT scan) conducted on the Episode Start Date or in the 28 days following the Episode Start Date.</p>	<p><b>Electronic Collection:</b> All patients aged 18-50 years as of December 31 of the measurement year with a new episode of low back pain. Follow steps below to determine denominator population.</p> <p>Step 1: Identify all patients ages 18-50 years who had an ambulatory encounter with a principal diagnosis of low back pain between January 1 and December 31 of the measurement year.</p> <p>Codes to identify ambulatory encounters for low back pain:</p> <p>Low back pain: ICD-9-CM Codes: 721.3, 722.10, 722.32, 722.52, 722.93, 724.02, 724.2, 724.3, 724.5, 724.6, 724.70, 724.71, 724.79, 738.5, 739.3, 739.4, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2.</p> <p>Evaluation and management codes – office or other outpatient services: CPT-Codes: 98925-98929, 98940-98942, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-, 99386, 99395, 99396-, 99401-99404, 99411, 99412, 99421, 99429, 99455-99456, 99499.</p> <p>Emergency department services and after-hours, non-emergency urgent care: CPT-Codes: 99281-99285, UB-92 Revenue Codes: 0450, 0451, 0452, 0456, 0459</p> <p>Outpatient and clinic services: UB-92 Revenue Codes: 051X, 0520-0523, 0526-0529, 057X-059X</p> <p>Professional fees, emergency and outpatient services: UB-92 Revenue Codes: 0981, 0982</p> <p>Professional fees, clinic: UB-92 Revenue: 0983</p>	<p>Exclusions are noted in the denominator specifications.</p>	<p>The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits, and procedures. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.</p> <p>As noted in the (more)</p>

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source	
<b>LOW BACK PAIN (LBP): USE OF IMAGING STUDIES</b> <i>continued</i>		Documentation of imaging study could include: physician orders for study, imaging results/report from radiologist, or other clear indication study performed during the timeframe.	<p>Step 2: Determine the Episode Start Date for each patient by identifying the date of patient's earliest encounter with a primary diagnosis of low back pain during the measurement year.</p> <p>Step 3: Determine if the Episode Start Date is a New Episode. Patients with a New Episode of low back pain must have a negative diagnosis history. Patients with a low back pain diagnosis within the previous 180 days of the Episode Start Date should be excluded from the denominator.</p> <p>Step 4: Exclude patients with an indication for imaging studies in the presence of low back pain.</p> <p>Cancer: ICD-9-CM Codes: 140208, 230-234, 235-239 (Recent) Trauma: ICD-9-CM Codes: 800, 839, 850-854, 860-869, 905-909, 926.11, 926.12, 929, 952, 958-959 (Recent) IV drug abuse: ICD-9-CM Codes: 304.0, 304.1X, 304.2X, 304.4X, 305.4X, 305.5X, 305.6X, 305.7X (Recent) Neurologic impairment: ICD-9-CM Codes: 344.60, 729.2.</p> <p><b>Denominator: Medical Record Collection:</b> A systematic sample of patients ages 18-50 years with a new episode of low back pain.</p>			measure description; those practices that have electronic health records system can use either the electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: INITIAL ASSESSMENT	NCQA <sup>2</sup>	<p>Patients with a diagnosis of back pain who have medical record documentation of all of the following on the date of the initial visit to the physician.</p> <p><b>Frequency:</b> On the date of the initial visit to the physician. (Initial visit = The date of the earliest encounter with the applicant for an eligible diagnosis.)</p> <p><b>FACTOR 1: PAIN ASSESSMENT</b></p> <p>The number of patients with documentation of assessment of pain on the date of the initial visit with the physician.</p> <p><b>Documentation Requirements:</b></p> <ul style="list-style-type: none"> <li>■ Date of assessment</li> <li>■ Use of any of the following assessment tools will satisfy the pain assessment requirement:</li> </ul> <ul style="list-style-type: none"> <li>● SF-36</li> <li>● Oswestry Low Back Pain Disability Questionnaire</li> <li>● Roland-Morris Disability Questionnaire</li> <li>● Quebec Pain Disability Scale</li> <li>● Sickness Impact Profile</li> <li>● Multidimensional Pain Inventory</li> </ul> <ul style="list-style-type: none"> <li>■ If there is no evidence of any of the above tools in the medical record, documentation of any of the following pain scales is acceptable.</li> </ul> <ul style="list-style-type: none"> <li>● McGill Pain Questionnaire</li> <li>● Visual analog scale</li> <li>● Brief pain inventory</li> <li>● Chronic pain grade</li> </ul>	<p>The total patient sample with low back pain (see codes table below).</p>		Medical record.  (more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: INITIAL ASSESSMENT <i>continued</i>		<ul style="list-style-type: none"> <li>• Neuropathic pain scale</li> <li>• Numerical rating scale (e.g., pain intensity 1-10)</li> <li>• Verbal descriptive scale (e.g., pt. report: "burning, shooting, stabbing")</li> <li>• Faces pain scale</li> <li>• Other.</li> </ul>			

**FACTOR 2: FUNCTIONAL STATUS**

The number of patients with documentation of assessment of functional status on the date of the initial visit with the physician.

**Documentation Requirements:**

- Date of assessment
- Use of any of the following assessment tools will satisfy the functional assessment requirement:
  - SF-36
  - Oswestry Low Back Pain Disability Questionnaire
  - Roland-Morris Disability Questionnaire
  - Quebec Pain Disability Scale
  - Sickness Impact Profile
  - Multidimensional Pain Inventory
  - Other
- If there is no evidence of any of the above tools in the medical record, there must be documentation that activities of daily living (ADLs) were assessed. Assessment of all of the following ADLs must be documented:
  - (more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: INITIAL ASSESSMENT <i>continued</i>		<ul style="list-style-type: none"> <li>• Eating</li> <li>• Bathing</li> <li>• Using the toilet</li> <li>• Dressing</li> <li>• Getting up from bed or a chair.</li> </ul>			

**FACTOR 3: PATIENT HISTORY**

The number of patients with documentation of a patient history that notes absence or presence of "red flags" as listed below on the date of the initial visit with the physician.

Definition – Red Flags:

- History of cancer
  - Unexplained weight loss
- Current infection
- Immunosuppression
- Fracture or suspected fracture
  - Motor vehicle accident or industrial injury with suspicion of fracture
  - Major fall with suspicion of fracture
- Cauda equina syndrome or progressive neurologic deficit
  - Saddle anesthesia
  - Recent onset bladder dysfunction (urine retention, increased frequency, overflow incontinence)
  - Recent onset fecal incontinence (loss of bowel control)
  - Major motor weakness.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: INITIAL ASSESSMENT <i>continued</i>		<p>Documentation Requirements:</p> <ul style="list-style-type: none"> <li>■ Date of the patient history</li> <li>■ Documentation necessary to satisfy assessment for red flags can include the following:           <ul style="list-style-type: none"> <li>• Indication/notation of presence or absence of red flags.</li> </ul> </li> </ul>	<p><b>FACTOR 4: ASSESSMENT OF PRIOR TREATMENT AND RESPONSE</b></p> <p>The number of patients with documentation of assessment of their previous history of back pain treatment and response, if applicable, on the date of the initial visit with the physician.</p> <p><b>Documentation Requirements:</b></p> <ul style="list-style-type: none"> <li>■ Date of the assessment</li> <li>■ Clear notation that the patient has been queried about back pain episode(s), treatment, and response</li> <li>■ Notation could include the following:           <ul style="list-style-type: none"> <li>• No prior back pain</li> <li>• Diagnosis and dates of back pain reports for the previous two years, or as far back as the patient is able to provide information</li> <li>• Report from referring physician with summary of back pain history</li> <li>• Patient report of history and attempted treatments, including diagnostic tests (e.g., imaging).</li> </ul> </li> </ul>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: INITIAL ASSESSMENT <i>continued</i>		<b>FACTOR 5: EMPLOYMENT STATUS</b> The number of patients with assessment of employment status on the date of the initial visit with the physician. <b>Documentation Requirements:</b> <ul style="list-style-type: none"> <li>■ Date of assessment</li> <li>■ Evidence of use of either of the following assessment tools will satisfy this requirement:               <ul style="list-style-type: none"> <li>● Sickness Impact Profile</li> <li>● Multidimensional Pain Inventory</li> </ul> </li> <li>■ If there is no evidence of either of the above tools in the medical record, variables of an employment assessment can count. These variables must include documentation of at least one of the following:               <ul style="list-style-type: none"> <li>● Type of work, including job tasks that may affect back pain management</li> <li>● Work status (e.g., out of work, part-time work, work with or without limitations)                   <ul style="list-style-type: none"> <li>● If patient is not working or limited in work capacity, length of time for work limitations</li> <li>■ Workers' compensation or litigation involvement.</li> </ul> </li> </ul> </li> </ul>			

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: PHYSICAL EXAM	NCQA	The number of patients with documentation of a physical exam on the date of the initial visit with the physician.  Frequency: On the date of the initial visit to the physician.(Initial visit = The date of the earliest encounter with the applicant for an eligible diagnosis.)  Documentation requirements: <ul style="list-style-type: none"><li>■ Date of the physical exam</li><li>■ For patients with radicular symptoms, documentation of physical exam must include the following, at a minimum:<ul style="list-style-type: none"><li>● Indication of straight leg raise test; AND notation of completion of neurovascular exam (a neurovascular exam must include ankle and knee reflexes; quadriceps; ankle and great toe dorsiflexion strength; plantar flexion; muscle strength; motor testing; pulses in lower extremities; and sensory exam)</li><li>■ For patients without radicular symptoms, documentation of physical exam must include the following:<ul style="list-style-type: none"><li>● Documentation of straight leg raise or neurovascular exam or clear notation of absence or presence of neurologic deficits.</li></ul></li></ul></li></ul>	The total patient sample with low back pain (see codes table below).		Medical record.

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: MENTAL HEALTH ASSESSMENT	NCQA	<p>The number of patients with at least one mental health assessment during the Eligible Episode.</p> <p><b>Frequency:</b> At least once during the Eligible Episode; timing is dependent on denominator criteria as specified below.</p> <p><b>Documentation Requirements:</b></p> <ul style="list-style-type: none"> <li>■ Determine if the patient has had back surgery or epidural steroid injection, which indicates an intervention has occurred</li> <li>■ If the patient has evidence of a back pain intervention, determine if a mental health assessment occurred prior to the date of intervention           <ul style="list-style-type: none"> <li>● Count only patients with documentation of a mental health assessment prior to intervention toward the numerator</li> <li>■ If there is no evidence of a back pain intervention, determine if the patient's pain duration is six weeks or more at any time during the Eligible Episode               <ul style="list-style-type: none"> <li>● If the patient's pain duration is six weeks or more, determine if a mental health assessment occurred at least once during the treatment Eligible Episode</li> <li>● Count a mental health assessment that occurs any time during the Eligible Episode toward the numerator</li> </ul> </li> </ul> </li> <li>■ Date of assessment</li> <li>■ Use of the following assessment tools will satisfy this requirement           <ul style="list-style-type: none"> <li>● SF-36 or SF-12</li> <li>● Sickness Impact Profile</li> <li>● Multidimensional Pain Inventory</li> </ul> </li> </ul>	<p>Back pain patients who meet either of the following criteria:</p> <ul style="list-style-type: none"> <li>■ Evidence of back surgery or epidural steroid injection</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ More than six weeks pain duration.</li> </ul>		Medical record.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: MENTAL HEALTH ASSESSMENT <i>continued</i>		<ul style="list-style-type: none"> <li>■ If there is no evidence of any of the above comprehensive assessment tools in the medical record, evidence of the following mental health assessment tools will satisfy this requirement:           <ul style="list-style-type: none"> <li>• PHQ-9</li> <li>• PHQ-2 (mood or anhedonia screener)</li> <li>• Distress and Risk Assessment Method (DRAM)</li> <li>• Zung Scale</li> <li>• Symptom Check List (SCL-90-R)</li> <li>• Beck Depression Inventory</li> <li>• Millon Behavioral Health Inventory</li> <li>• Minnesota Multiphasic Personality Inventory</li> <li>• Other</li> </ul> </li> <li>■ If there is no evidence of any of the above tools in the medical record, elements of a mental health assessment can be counted. Documentation of any of the following elements counts as a mental health assessment           <ul style="list-style-type: none"> <li>• Affect</li> <li>• Cognition</li> <li>• Anxiety/stress</li> <li>• Coping</li> <li>• Fear</li> <li>• Depression</li> <li>• Distress</li> <li>• Anger.</li> </ul> </li> </ul>		<p>Documentation of active depression treatment by a physician or behavioral health practitioner counts toward this numerator.</p> <p>(more)</p>	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: APPROPRIATE IMAGING FOR ACUTE BACK PAIN	NCQA	The number of patients with an order for or report on an imaging study during the six weeks after pain onset.  <b>Documentation Requirements:</b> <ul style="list-style-type: none"><li>■ Determine the date of pain onset. This is the day the patient indicates that back pain started<ul style="list-style-type: none"><li>• If the patient cannot specify the exact date, determine approximate number of days the pain has been present and convert into weeks</li><li>• If the date of pain onset, or patient estimate, is not documented, use the initial visit date as the pain onset date</li></ul></li><li>■ Determine if there is documentation of the presence of any of the following red flags:<ul style="list-style-type: none"><li>• History of cancer</li><li>• Current infection</li><li>• Fracture or suspected fracture</li><li>• Cauda equina syndrome.</li></ul></li></ul>	Patients with back pain lasting six weeks or less.	Patients with documentation of red flags.	Medical record.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>LBP: APPROPRIATE IMAGING FOR ACUTE BACK PAIN</b> <i>continued</i>		<ul style="list-style-type: none"> <li>■ Include in the numerator both physician orders for imaging studies AND radiology reports that occurred any time from the date of pain onset through six weeks after pain onset</li> <li>■ Include only orders and reports generated by the applicant physician or practice.</li> </ul>			
<b>LBP: REPEAT IMAGING STUDIES</b>	NCQA	<p>The number of patients with inappropriate imaging studies (as defined below).</p> <p><b>Documentation Requirements:</b></p> <ul style="list-style-type: none"> <li>■ Include all imaging studies ordered or documented from the date of the initial visit to the end of the Eligible Episode</li> <li>■ The following types of imaging studies should be counted toward the numerator of this measure, unless otherwise specified below</li> </ul> <ul style="list-style-type: none"> <li>● Plain x-ray</li> <li>● Bone scan</li> <li>● MRI</li> <li>● Myleography</li> <li>● Discography</li> <li>● CT scan</li> </ul> <p>■ Determine if more than one imaging study has been ordered or if a report is present during the Eligible Episode. If the patient has been under the care of another physician, there should be documentation that the patient was asked about prior imaging studies and attempts made to get those studies/reports</p> <ul style="list-style-type: none"> <li>● Patients with one imaging study or no documentation of assessing for prior studies count toward the numerator</li> </ul>	<p>Patients with more than one imaging study and patients with only one imaging study and no documentation in medical record of physician asking about prior imaging.</p>	<p>Patients with red flags or worsening/progressive signs.</p>	Medical record.  (more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: REPEAT IMAGING STUDIES <i>continued</i>		<ul style="list-style-type: none"> <li>• Include imaging studies in the numerator and denominator if they have been ordered by the applicant or if there are imaging reports from another provider</li> <li>■ Do not include CT scan or MRI toward the numerator if the first imaging study is a plain x-ray. If the patient is a surgical patient, the following rules apply:           <ul style="list-style-type: none"> <li>• Do not count an imaging study (MRI, CT scan, myelography only) as a repeat in the numerator if it occurs in the 12 weeks prior to the surgical date</li> <li>• If the surgical procedure was instrumented fusion or disc replacement, do not count plain, postoperative x-rays toward the numerator.</li> <li>• Do not count an imaging study toward the numerator that occurs postoperatively as a repeat if there is documentation of surgical complications</li> <li>■ Exclude patients from the denominator with evidence or notation of any of the following in their medical record in the seven-day (one-week) period preceding the second imaging study.               <ul style="list-style-type: none"> <li>• Red flags (e.g., history of cancer, current infection, fracture or suspected fracture, cauda equina syndrome)</li> <li>• Worsening/progressive signs (e.g., objective findings of progressive neurologic symptoms such as new sciatica; new or worsening numbness or weakness; or physical exam findings indicating new missing reflex or worsening weakness).</li> </ul> </li> </ul> </li> </ul> <p><i>Note:</i> Failure to respond to treatment is not an indication of worsening symptoms.</p>		(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>LBP:ADVICE FOR NORMAL ACTIVITIES</b>	NCOA	The number of patients with documentation of advice to maintain or resume normal activities on the date of the initial visit with the physician.  Frequency: On the date of the initial visit to the physician.	The total patient sample with low back pain (see codes table below).		Medical record.
<b>LBP:ADVICE AGAINST BED REST</b>	NCOA	Documentation requirements: <ul style="list-style-type: none"> <li>■ The date of notation on which the advice was provided</li> <li>■ A clear notation that the patient was advised to either maintain or resume normal activity or the activities of daily living as early as possible in the course of back pain.</li> </ul> Frequency: On the date of the initial visit to the physician.	The number of patients with documentation of advice against bed rest of four days or longer on the date of the initial visit with the physician.  Definition of extended bed rest: Bed rest lasting four days or longer.	The total patient sample with low back pain (see codes table below).	Medical record.

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: RECOMMENDATIONS FOR EXERCISE	NQCA	The number of patients with documentation that a supervised exercise program was recommended or that they were provided instructions for therapeutic exercise with follow-up by the physician.  Frequency: At least once during the Eligible Episode.	Patients with back pain lasting more than 12 weeks.		Medical record.

**Documentation Requirements:**

At a minimum, documentation in medical record must include a note indicating the date on which exercise was directed or a supervised exercise program was recommended.

- Documentation that supervised exercise was recommended

OR

- Documentation that instructions for therapeutic exercise were provided on appropriate strengthening, stretching, conditioning, aerobic or mobility exercises. If the patient is expected to complete exercise program at home, there must also be documentation of provider follow-up to ensure correct form and duration of treatment.

**Definitions:**

Therapeutic exercise: Strengthening, general stretching, McKenzie method of passive end-range stretching exercises, conditioning, aerobic and conventional physical therapy (stretching, flexibility, and coordination exercises).

Supervised exercise: Must be instructed in the office or administered by a physical therapist or other trained professional. Physical therapy must involve active participation by the patient.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>LBP: APPROPRIATE USE OF EPIDURAL STEROID INJECTIONS</b>	NCQA	<p>The number of patients who have received an epidural steroid injection during the Eligible Episode in the absence of radicular pain and patients with radicular pain who received an epidural injection without image guidance.</p> <p><b>Documentation Requirements:</b></p> <ul style="list-style-type: none"> <li>■ Determine if there is documentation of radicular pain</li> <li>● If there is documentation of radicular pain, determine if there is documentation of the use of image guidance to validate epidural placement of the steroid. Patients without documentation of image guidance count toward the numerator</li> <li>● All patients with documentation of an epidural steroid injection, but without documentation of radicular pain count toward the numerator</li> <li>■ Documentation of the epidural steroid injection can include the following:           <ul style="list-style-type: none"> <li>● Notation of order or referral for epidural steroid injection</li> <li>● Notation of administration of epidural steroid injection by applicant.</li> </ul> </li> </ul> <p><b>Definitions:</b> Radicular pain: Pain experienced along the dermatome (sensory distribution) of a nerve due to pressure on the nerve root.</p>	<p>The total patient sample with low back pain (see codes table below).</p>		Medical record.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>LBP: SURGICAL TIMING</b>	NCQA	The number of patients with a surgical intervention to treat back pain within the first six weeks of pain.  <b>Definitions:</b> Cauda equina syndrome: Progressive loss of nerve function, including bowel and bladder incontinence.	Patients who have had back surgery.	Patients with documentation of a red flag: <ul style="list-style-type: none"> <li>■ History of cancer</li> <li>■ Current infection</li> <li>■ Fracture or suspected fracture</li> <li>■ Cauda equina syndrome.</li> </ul>	Medical record.
<b>LBP: PATIENT REASSESSMENT</b>	NCQA	<b>FACTOR 1: PAIN REASSESSMENT</b>  The number of patients with documentation of reassessment of pain within four to six weeks of their initial back pain visit or of a surgical procedure date.  <b>Frequency:</b> Nonsurgical patients: Reassessment should occur within four to six weeks of the initial visit date. Surgical patients: Reassessment should occur within four to six weeks of the surgical procedure date. If there is more than one surgical procedure, a reassessment should be conducted for each occurrence.  <b>Measure Calculation:</b> <ul style="list-style-type: none"> <li>■ Do not count patients toward the numerator who do not have documentation of a pain assessment at their initial visit with the physician</li> <li>■ Do not count assessment of pain that occurs as part of the initial patient assessment toward the reassessment numerator</li> <li>■ Determine if the patient has evidence of a surgical procedure within six weeks of the initial visit.</li> </ul>		(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: PATIENT REASSESSMENT <i>continued</i>		<ul style="list-style-type: none"> <li>• If there is evidence of a surgical procedure, the reassessment of pain should be documented within four to six weeks of the surgical procedure</li> <li>• If there is no evidence of a surgical procedure:           <ul style="list-style-type: none"> <li>– The reassessment of functional status should be documented within four weeks of the initial visit, but no later than six weeks from the initial visit date</li> <li>– Count assessment of pain toward the numerator only if it occurs within the timeframes outlined above.</li> </ul> </li> </ul> <p>Follow-up visits do not need to be with a physician, but they must meet the above criteria.</p> <p><b>Documentation Requirements:</b></p> <ul style="list-style-type: none"> <li>■ Date of assessment.</li> <li>■ Use of the following assessment tools will satisfy this requirement:           <ul style="list-style-type: none"> <li>● SF-36</li> <li>● Oswestry Low Back Pain Disability Questionnaire</li> <li>● Roland-Morris Disability Questionnaire</li> <li>● Quebec Pain Disability Scale</li> <li>● Sickness Impact Profile</li> <li>● Multidimensional Pain Inventory</li> </ul> </li> </ul> <p>■ If there is no evidence of any of the above tools in the medical record, documentation of any of the following pain scales is acceptable:</p> <ul style="list-style-type: none"> <li>● McGill Pain Questionnaire</li> <li>● Visual analog scale</li> </ul>		(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: PATIENT REASSESSMENT <i>continued</i>		<ul style="list-style-type: none"> <li>• Brief pain inventory</li> <li>• Chronic pain grade</li> <li>• Neuropathic pain scale</li> <li>• Numerical rating scale (e.g., pain intensity 1-10)</li> <li>• Verbal descriptive scale (e.g., patient report: “burning, shooting, stabbing”)</li> <li>• Faces pain scale</li> <li>• Other.</li> </ul>			

**FACTOR 2: FUNCTIONAL STATUS**

The number of patients with documentation of reassessment of functional status within four to six weeks of their initial back pain visit or of a surgical procedure date.

**Frequency:**

Nonsurgical patients: Reassessment should occur within four to six weeks of the initial visit date.

Surgical patients: Reassessment should occur within four to six weeks of the surgical procedure date. If there is more than one surgical procedure, a reassessment should be conducted for each occurrence.

**Measure Calculation:**

- Do not count patients toward the numerator who do not have documentation of a functional status assessment at their initial visit with the physician
- Do not count functional status assessment that occurs as part of the initial patient assessment toward the numerator of the reassessment measure

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: PATIENT REASSESSMENT <i>continued</i>		<ul style="list-style-type: none"> <li>■ Determine if the patient has evidence of surgical procedure           <ul style="list-style-type: none"> <li>• If there is evidence of a surgical procedure, the reassessment of functional status should be documented within four to six weeks of the surgical procedure</li> <li>• If there is no evidence of a surgical procedure:               <ul style="list-style-type: none"> <li>– The reassessment of functional status should be documented within four to six weeks of the initial visit</li> <li>– Count an assessment of functional status toward the numerator only if it occurs within the timeframes outlined above.</li> </ul> </li> </ul> </li> </ul> <p>Follow-up visits do not need to be with a physician; however, they must meet the above criteria.</p> <p><b>Documentation Requirements:</b></p> <ul style="list-style-type: none"> <li>■ Date of assessment.</li> <li>■ Use of any of the following assessment tools will satisfy the requirement:           <ul style="list-style-type: none"> <li>• SF-36</li> <li>• Oswestry Low Back Pain Disability Questionnaire</li> <li>• Roland-Morris Disability Questionnaire</li> <li>• Quebec Pain Disability Scale</li> <li>• Sickness Impact Profile</li> <li>• Multidimensional Pain Inventory</li> <li>• Other</li> </ul> </li> </ul>			

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LBP: PATIENT REASSESSMENT <i>continued</i>		<ul style="list-style-type: none"> <li>■ If there is no evidence of any of the above tools in the medical record, there must be documentation that ADLs were assessed. All of the following ADLs must be documented:           <ul style="list-style-type: none"> <li>• Eating</li> <li>• Bathing</li> <li>• Using the toilet</li> <li>• Dressing</li> <li>• Getting up from bed or a chair.</li> </ul> </li> </ul>			Medical record.
LBP: SHARED DECISION-MAKING	NCQA	The number of patients who had surgery, with documentation in the medical record that a clinician and the patient discussed treatment options prior to surgery, including alternatives to surgery, risks and benefits, and evidence of effectiveness.	<p><b>Frequency:</b> At least once during the Eligible Episode prior to surgery.</p> <p><b>Documentation Requirements:</b> The patient record must contain written documentation that a clinician discussed the following related to the patient's condition:</p> <ul style="list-style-type: none"> <li>■ Treatment options, including alternatives to surgery</li> <li>■ Risks and benefits</li> <li>■ Evidence of effectiveness.</li> </ul> <p>Provision of a signed informed consent for a procedure or treatment does not meet the intent of this measure.</p>	(more)	A-49

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Description	Scoring	Data Source
LBP: PATIENT EDUCATION (STRUCTURAL MEASURE)	NQCA	The practice provides educational materials (e.g., brochures, pamphlets, web-based information, videos, other written or electronic materials) in lay language that includes the following information: <ul style="list-style-type: none"> <li>■ Natural history of low back pain</li> <li>■ Treatment options, including alternatives to surgery</li> <li>■ Risks and benefits</li> <li>■ Evidence base for different treatments.</li> </ul>	Patient educational materials include the following: <ol style="list-style-type: none"> <li>1. Natural history of low back pain</li> <li>2. Treatment options</li> <li>3. Risks and benefits</li> <li>4. Evidence base for different treatments</li> </ol>	Yes <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
LBP: POSTSURGICAL OUTCOMES (STRUCTURAL MEASURE)	NQCA	<b>ELEMENT A: TRACKS BACK SURGERY COMPLICATIONS</b>  <b>Documentation Requirements:</b> The physician demonstrates a system for collecting data on back surgery complications for 6-12 weeks after surgery. Ideally, the physician collects data on all back surgery patients to obtain a complete picture of complications. The 6- to 12-week period should start the day the patient undergoes the surgical procedure.  This requirement applies to physician applicants who perform back surgeries. Back surgery-related complications within 6-12 weeks of surgery may include, but are not limited to, the following: <ul style="list-style-type: none"> <li>■ Infection</li> <li>■ Wound dehiscence</li> <li>■ Hematoma</li> <li>■ CSF leak</li> <li>■ Other.</li> </ul>	<b>ELEMENT A: TRACKS BACK SURGERY COMPLICATIONS</b>  <b>Documentation Requirements:</b> To meet the requirements for this standard, the physician must submit a copy of the tracking tool used to identify the complications of back surgery. The physician tracks the following: <ol style="list-style-type: none"> <li>1. Wound infection</li> <li>2. Wound dehiscence</li> <li>3. Hematoma</li> <li>4. CSF leak</li> <li>5. Other</li> </ol>	Yes <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**BONE AND JOINT CONDITIONS (continued)**

Measure	IP Owner <sup>1</sup>	Description	Scoring	Data Source
LBP: POSTSURGICAL OUTCOMES (STRUCTURAL MEASURE) <i>continued</i>	ELEMENT B: ANALYZE SURGICAL OUTCOME DATA  The physician conducts a periodic analysis of surgical complications data and develops a plan for improving outcomes. The physician must demonstrate that there is a process for periodically:  ■ analyzing the surgical outcomes data to reduce the number and severity of surgical complications ■ improving surgical outcomes, based on the analysis.  The requirement applies to physicians who perform back surgeries and should include all patients having back surgery.	<b>ELEMENT B: ANALYZE SURGICAL OUTCOME DATA</b> Documentation Requirements: To meet the requirements for this standard, the physician must submit a copy of the data analysis and the plan for improving outcomes. Scoring: 1. The physician analyzes surgical outcomes data. 2. The physician has a plan for improving surgical outcome.	Yes <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Electronic or paper report summarizing postsurgical complications data and plan for improvement.

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Description	Scoring	Data Source										
LBP: EVALUATION OF PATIENT EXPERIENCE (STRUCTURAL MEASURE)	NCQA	<p><b>ELEMENT A: COLLECTS PATIENT EXPERIENCE DATA</b></p> <p>The physician collects data on patient experience of care.</p>	<p><b>ELEMENT A: COLLECTS PATIENT EXPERIENCE DATA</b></p> <p>Documentation Requirements:</p> <p>The instrument used to collect patient experience data, e.g., phone survey questions or a paper or electronic survey. The survey instrument addresses the following areas of patient experience:</p> <ul style="list-style-type: none"> <li>■ Patient access to care (e.g., the ability to make an appointment and see physician, timeliness and quality of phone calls, office wait time)</li> <li>■ Quality of physician communication with the patient (e.g., response to questions, instructions and information about diagnosis, treatment, medication, follow-up care)</li> <li>■ Patient confidence in self-care (e.g., patient knowledge of and ability to provide self-care involving activity, exercise, medications, reporting change in symptoms)</li> <li>■ Patient satisfaction with care (may include staff, e.g., explanation and concern, time with physician, staff, and treatment, e.g., pain management, x-ray work, prescriptions, lab work).</li> </ul> <p>Scoring:</p> <table> <tr> <td><b>Yes</b></td> <td><b>No</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<b>Yes</b>	<b>No</b>	<input type="checkbox"/>	<p>Patient survey instrument.</p>							
<b>Yes</b>	<b>No</b>													
<input type="checkbox"/>	<input type="checkbox"/>													
<input type="checkbox"/>	<input type="checkbox"/>													
<input type="checkbox"/>	<input type="checkbox"/>													
<input type="checkbox"/>	<input type="checkbox"/>													

## **Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

### **CODES TO IDENTIFY BACK PAIN DIAGNOSES**

Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "X," which represents a required digit. For example, ICD-9-CM Diagnosis Code 721.4X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.

<b>ICD-9-CM Code</b>	<b>Description</b>
721.3	Lumbosacral spondylosis without myelopathy
721.4, 721.4X	Thoracic or lumbar spondylosis with myelopathy
721.90	Spondylosis of unspecified site, without mention of myelopathy
722	Intervertebral disc disorders
	Displacement of thoracic or lumbar intervertebral disc without myelopathy
	Displacement of intervertebral disc, site unspecified without myelopathy
	Schmorl's nodes
	Intervertebral disc disorder with myelopathy—classified by region: unspecified, cervical, thoracic, lumbar
	Post laminectomy syndrome—classified by region: unspecified, cervical, thoracic, lumbar
	Other and unspecified disc disorder (calcification of intervertebral cartilage or disc, discitis) classified by region: unspecified, cervical, thoracic, lumbar
723.0	Spinal stenosis in cervical region
724.0X	Spinal stenosis, other than cervical—classified by region—unspecified region other than cervical, thoracic, lumbar, other region other than cervical
724.2	Lumbago
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis
724.5	Backache, unspecified
724.6	Disorders of sacrum
724.70	Unspecified disorder of coccyx
724.71	Hypermobility of coccyx
724.79	Disorders of coccyx, other
728.4	Acquired spondyloolisthesis (degenerative spondyloolisthesis, spondylolisthesis, acquired; excludes congenital)
756.12	Congenital spondyloolisthesis
738.5	Other acquired deformity of the back or spine
739.3	Nonallogenic lesion of lumbar region, not elsewhere classified
739.4	Nonallogenic lesion of lumbar region, not elsewhere classified
846.0	Sprains and strains of sacroiliac region, lumbosacral
846.1	Sprains and strains of sacroiliac region, sacroiliac ligament
846.2	Sprains and strains of sacroiliac region, sacrospinatus
846.3	Sprains and strains of sacroiliac region, sacrotuberous
846.8	Sprains and strains of sacroiliac region, other specified sites of sacroiliac region
846.9	Sprains and strains of sacroiliac region, unspecified site of sacroiliac region
847.2	Sprains and strains of other and unspecified parts of back, lumbar

## **Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

### **CODES TO IDENTIFY SURGICAL PROCEDURES**

<b>Procedure Type</b>	<b>CPT Codes*</b>	<b>ICD-9 Procedure Codes</b>
Osteotomy	22210, 22214, 22220, 22222, 22224, 22226	
Athrodesis	22532-22534, 22548, 22554, 22556, 22558-22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632	
Kyphectomy	22818, 22819	
Spinal fusion	22830, 22840-22849	81XX
Laminectomy	63001-63017, 63048, 63170-63173, 63180-63182, 63185, 63190, 63191, 63194-63200	03.02
Laminotomy	63020, 63030, 63035, 63040, 63042-63048	
Decompression—spinal cord, equina, and/or nerve root (herniated intervertebral disc)	63055-63057, 63064, 63066	03.09
Diskectomy	63075-63078	80.5X
Vertebral corpectomy	63081, 63082, 63085-63088, 63090, 63091, 63101-63103	

\*CPT® is a trademark of the American Medical Association. Current Procedure Terminology (CPT) is copyright 2005 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE</b>	NCQA <sup>2,4</sup>	<p>Electronic Collection: Patients who were appropriately treated or tested for osteoporosis after the fracture. Appropriate treatment or testing is defined by any one of the three criteria below:</p> <ul style="list-style-type: none"> <li>■ Had a BMD test on the Index Episode Start Date or in the 180-day period after the Index Episode Start Date</li> <li>■ Had a BMD test during the acute care inpatient stay for the fracture (applies only to fractures requiring hospitalization)</li> <li>■ Dispensed a prescription to treat osteoporosis on the Index Episode Start Date or in the 180-day period after the Index Episode Start Date.</li> </ul> <p>Codes to identify bone mineral density test</p> <p>Computerized axial tomography bone density study: CPT: 76070, 76071</p> <p>Dual energy x-ray absorptiometry (DEXA), bone density study CPT: 76075-76077</p> <p>Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry) CPT: 76078</p> <p>Ultrasound bone density measurement and interpretation CPT: 76977</p> <p>Bone density (bone mineral content) study CPT: 78350-78351 ICD-9-CM: 88.98</p> <p>Special screening for osteoporosis ICD-9-CM Codes: V82.81</p> <p>HCPGs: G0130</p>	<p><b>Electronic Data Collection:</b> Women 67 years and older* as of December 31 of the measurement year who had a fracture between July 1 of the year prior to the measurement year through June 30 of the measurement year. If a patient has more than one fracture during the specified period, include only the first fracture identified through the following criteria:</p> <p>Step 1: Select the first eligible fracture during the 12-month Intake Period.</p> <p>Step 2: Identify the Index Episode Start Date and negative diagnosis history. For each patient identified in step 1, determine the Index Episode Start Date by finding the earliest fracture in the 12-month period.</p> <p>Identify patients who were diagnosed with a new fracture by determining if the patient has a negative diagnosis history. Patients with a diagnosis of fracture within 60 days prior to the Index Episode Start Date should be excluded from the measure. For patients with an inpatient stay, use the admission date to determine a negative diagnosis history.</p> <p>Step 3: Exclude patients who have received osteoporosis testing or treatment in the prior year. Exclude patients who had a BMD test during the 365 days prior to the Index Episode Start Date. For patients with an inpatient stay, use the admission date to determine a negative diagnosis. Exclude patients who received any medication listed during the 365 days prior to the Index Episode Start Date. For patients with an inpatient</p>	<p>Included in specifications above.</p>	<p>The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits, procedures, and pharmacy.</p> <p>The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.</p> <p>As noted in the measure (more)</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE</b> <i>continued</i>		<p>FDA approved osteoporosis therapies:</p> <ul style="list-style-type: none"> <li>■ Alendronate</li> <li>■ Risedronate</li> <li>■ Calcitonin</li> <li>■ Raloxifene</li> <li>■ Estrogen</li> <li>■ Teriparatide</li> <li>■ Alendronate-cholecalciferol (Fosamax Plus D)</li> <li>■ Ibandronate (Boniva)</li> <li>■ Injectable Estrogens</li> </ul> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator:</b> Documentation of appropriate treatment or testing for osteoporosis after the fracture. Appropriate treatment or testing is defined by any one of the three criteria below:</p> <ul style="list-style-type: none"> <li>■ Documentation of a BMD test on the index Episode Start Date or in the 180-day period after the Index Episode Start Date</li> <li>■ Documentation of a BMD test during the acute care inpatient stay for the fracture (applies only to fractures requiring hospitalization)</li> <li>■ Documentation of a prescription to treat osteoporosis on the Index Episode Start Date or in the 180-day period after the Index Episode Start Date.</li> </ul>	<p>stay, use the admission date to determine a negative medication history.</p> <p>Codes to identify fractures:</p> <p>CPT Codes: 21800, 21825, 22305, 22328, 22520, 22521, 22523, 22524, 23500, 23515, 23570, 23630, 23665, 23680, 24500, 24587, 24620, 24635, 24650, 24685, 25500, 25652, 25680, 25685, 27193, 27248, 27254, 27250, 272514, 272520, 272540, 27750, 27828</p> <p>HPCPs: S2360, S2362</p> <p>ICD-9-CM Codes: 79.00-79.03, 79.05-79.07, 79.09, 79.10-79.13, 79.15-79.17, 79.19, 79.20-79.23, 79.25-79.27, 79.29, 79.30-79.33, 79.35-79.37, 79.39, 79.60-79.63, 79.65-79.67, 79.69, 81.65, 81.66, 733.1, 805-806, 807.0-807.4, 808-815, 818-825, 827, 828</p> <p>DRGs: 235, 236.</p> <p>Fractures of the finger, toe, face, and skull are not included in this measure.</p> <p>*Note: Given the measurement look-back period, women 65 years and older will be captured in this measure.</p> <p><b>Medical Record Collection:</b> A systematic sample of women 67 years and older* as of December 31 of the measurement year who had a fracture between July 1 of the year prior to the measurement year through June 30 of the measurement year. If a patient has more than one fracture during the specified period, include only the first fracture identified through the following criteria:</p>	<p>(more)</p>	<p>description, those practices that have electronic health records system can use either the electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE</b> <i>continued</i>		<p>The following describe BMD tests and treatments for the prevention of osteoporosis:</p> <ul style="list-style-type: none"> <li>■ Computerized axial tomography bone density study</li> <li>■ Dual energy x-ray absorptiometry (DEXA), bone density study</li> <li>■ Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry)</li> <li>■ Ultrasound bone density measurement and interpretation</li> <li>■ Bone density (bone mineral content) study</li> <li>■ Special screening for osteoporosis.</li> </ul> <p>All allowable therapies:</p> <ul style="list-style-type: none"> <li>■ Alendronate</li> <li>■ Risedronate</li> <li>■ Calcitonin</li> <li>■ Raloxifene</li> <li>■ Estrogen</li> <li>■ Teriparatide</li> <li>■ Alendronate-cholecalciferol (Fosamax Plus D)</li> <li>■ Ibandronate (Boniva)</li> <li>■ Injectable estrogens.</li> </ul>	<p>Step 1: Select the first eligible fracture documented during the 12-month Intake Period</p> <p>Step 2: Identify the Index Episode Start Date and negative diagnosis history. For each patient identified in step 1, determine the Index Episode Start Date by finding the earliest fracture documented in the 12-month period. Identify patients who were diagnosed with a new fracture by determining if the patient has a negative diagnosis history. Patients with a documented diagnosis of fracture within 60 days prior to the Index Episode Start Date should be excluded from the measure. For patients with an inpatient stay, use the admission date to determine a negative diagnosis.</p> <p>Step 3: Exclude patients who have received documented osteoporosis testing or documented treatment in the prior year. Exclude patients who had documentation for a BMD test during the 365 days prior to the Index Episode Start Date. For patients with an inpatient stay, use the admission date to determine a negative diagnosis.</p> <p>Exclude patients who were prescribed any medication listed above during the 365 days prior to the Index Episode Start Date. For patients with an inpatient stay, use the admission date to determine a negative medication history. Fractures of the finger, toe, face, and skull are not included in this measure.</p>	<p>*Note: Given the measurement look-back period, women 65 years and older will be captured in this measure.</p> <p>(more)</p>	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE</b> <i>continued</i>			<p>Definitions:</p> <p>Index Episode Start Date: The date of service for any outpatient claim/encounter during the Intake Period with a diagnosis of fracture. For fractures requiring hospitalization (inpatient), the date of service is the date of discharge from the inpatient setting.</p> <p>Intake Period: A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period is used to capture Eligible Episodes.</p> <p>Negative diagnosis history: A period of 60 days prior to the Index Episode Start Date, during which time the patient had no diagnosis of fracture. For fractures requiring an inpatient stay, use the date of admission to determine a negative diagnosis history.</p>	<p>Exclude the following patients from the denominator:</p> <p>Women who are identified as being pregnant (ICD-9-CM Codes: 630-677, V22-V23, V28), during the measurement year.</p> <p>Patients who have been diagnosed with human immunodeficiency virus (ICD-9-CM Codes: 042, V08). At the health plan level, the reporting of the measure is stratified by insurance coverage (commercial, Medicare and Medicaid).</p>	<p>According to NCQA, the electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits, and pharmacy. The medical record option requires manual or (more)</p>
<b>ARTHRITIS: DISEASE MODIFYING ANTI-RHEUMATIC DRUG THERAPY IN RHEUMATOID ARTHRITIS</b>	NCQA <sup>24</sup>	<p><b>Electronic Collection:</b> Patients who had at least one ambulatory prescription dispensed for a disease modifying anti-rheumatic drug (DMARD) during the measurement year.</p> <p><b>DMARD List:</b></p> <ul style="list-style-type: none"> <li>■ Methotrexate</li> <li>■ Sulfasalazine</li> <li>■ Leflunomide</li> <li>■ Hydroxychloroquine</li> <li>■ Infliximab* J1745</li> <li>■ Cyclophosphamide * J9070, J9080, J9090, J9096</li> <li>■ Penicillamine</li> <li>■ Etanercept * J1438</li> <li>■ Anakinra</li> </ul>	<p><b>Electronic Collection:</b> All patients ages 18 years and older as of December 31 of the measurement year, with a diagnosis of RA. Two face-to-face physician encounters with a rheumatoid arthritis diagnosis with different dates of service in an ambulatory or non-acute inpatient setting between January 1 and November 30 of the measurement year are required to confirm an RA diagnosis.</p> <p>Codes to identify ambulatory/non-acute services for RA:</p> <p>ICD-9-CM: 714.0, 714.1, 714.2, 714.81</p> <p>CPT Codes (outpatient/non-acute inpatient services): 99201-99205, 99211-99215, 99241-99245, 99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337, 99341-99345, 99347-99350, 99350, 99384-99387,</p>		

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### BONE AND JOINT CONDITIONS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ARTHRITIS: DISEASE MODIFYING ANTI- RHEUMATIC DRUG THERAPY IN RHEUMA- TOID ARTHRITIS</b> <i>continued</i>		<ul style="list-style-type: none"> <li>■ Gold (oral or intramuscular)</li> <li>■ Cyclosporine</li> <li>■ Azathioprine * J7501</li> <li>■ Adalimumab</li> <li>■ Minocycline</li> <li>■ Staphylocal Protein A</li> <li>■ Abatacept.</li> </ul> <p>* A list of NDC Codes is available on NCQA's web site <a href="http://www.ncqa.org">www.ncqa.org</a>.</p>	<p>99294-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499</p> <p>UB-92 Revenue Codes (Outpatient/non-acute inpatient services): 0118, 0128, 0138, 0148, 0158, 019X 051X, 0520-0523, 0526-0529, 055X, 057X-059X, 066X, 077X, 0982, 0983.</p> <p><b>Medical Record Collection:</b> A systematic sample of patients, ages 18 years and older as of December 31 of the measurement year, with a diagnosis of RA. Two face-to-face physician encounters with a rheumatoid arthritis diagnosis with different dates of service in an ambulatory or non-acute inpatient setting between January 1 and November 30 of the measurement year are required to confirm an RA diagnosis.</p> <p><b>Medical Record Data Specifications:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population.</p> <p><b>Numerator:</b> <b>Medical Record Collection:</b> Patients who had documentation of at least one ambulatory prescription for a DMARD (medication list above) during the measurement year.</p>		<p>electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator. As noted in the measure description, those practices that have electronic health records system can use either the electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p> <p>(more)</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

DIABETES					
Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
EYE EXAM	Alliance/ NCQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> An eye screening for diabetic retinal disease as identified by administrative data. This includes those patients with diabetes who had one of the following:</p> <ul style="list-style-type: none"> <li>■ A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. The following codes may be used to identify eye exams*. CPT Codes 67038, 67040, 67101, 67105, 67107-67108, 67110, 67112, 67141, 67145, 67208, 67210, 67218, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 99203-99205, 99213-99215, 99242-99245; HCPCS: S0620, S0621, S0652, S3000; ICD-9-CM Codes 14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16, V72.0</li> </ul> <p>*Eye exams provided by eye care professionals are a proxy for dilated eye examinations because there is no administrative way to determine that a dilated exam was performed. CPT Category II Code 2022F may be used within the measurement year to identify a dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed. CPT Category II Code 2024F may be used within the measurement year to identify a seven standard field stereoscopic photo with interpretation by an ophthalmologist or optometrist documented and reviewed. CPT Category II Code 2026F.</p>	<p><b>Electronic Collection:</b> Exclude patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) who did not have any face-to-face encounters with the diagnosis of diabetes (see codes for diabetes above), in any setting, during the measurement year or year prior to the measurement year. Exclude patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Codes 251.8, 962.0) during the measurement year.</p> <p><b>Medical Record Collection:</b> Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement year.</p> <p>*Codes to identify patients with diabetes include:</p> <ul style="list-style-type: none"> <li>■ Diabetes diagnosis: ICD-9-CM Codes 250, 357.2, 362.0, 366.41, 648.0; DRGs 294, 295</li> <li>■ Outpatient/non-acute inpatient: CPT Codes 92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411,</li> </ul>	<p>Electronic data (visit, procedure, procedure results and pharmacy encounter data or claims) or medical record data (paper based or EHR). This measure requires the use of claims/encounter, pharmacy data, or medical record data for identification of diabetes for the denominator, and claims/encounter data, or medical record data for identification of diabetes for the denominator, and claims/encounter data, or medical record review to indicate whether an eye exam was performed.</p> <p>(more)</p>	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### DIABETES (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>EYE EXAM</b> <i>continued</i>		<ul style="list-style-type: none"> <li>■ A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year. An automated result must be available. CPT Category II Code 3072F may be used within the measurement year to identify low risk for retinopathy (no evidence of retinopathy in the prior year).</li> </ul> <p><b>Medical Record Collection:</b> An eye screening for diabetic retinal disease. This includes diabetics who had one of the following:</p> <ul style="list-style-type: none"> <li>■ A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year</li> <li>■ A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year.</li> </ul> <p>Documentation in the medical record of a retinal eye exam during the measurement year or a <i>negative</i> retinal eye exam during the year prior to the measurement year must include:</p> <ul style="list-style-type: none"> <li>■ A note or letter from an ophthalmologist, optometrist or other health care professional summarizing the date on which the procedure was performed and the results of a retinal evaluation performed by an eye-care professional OR</li> <li>■ A chart or photograph of retinal abnormalities.</li> </ul> <p>If fundus photography was used in the exam, there must be documentation in the medical record indicating the date on which the procedure was performed and evidence that</p>	<p>99412, 99420, 99429, 99455, 99456, 99499, UB-92 Revenue Codes 0118, 0128, 0138, 0148, 0158, 019X, 051X, 052 0-0523, 0524, 0525, 0526-0529, 055X, 057X-059X, 066X, 077X, 082X-085X, 088X, 0982, 0983</p> <ul style="list-style-type: none"> <li>■ Acute inpatient/emergency department: (CPT Codes 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99285, 99291; UB-92 Revenue Codes 010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 045X, 072X, 080X, 0981, 0987.</li> </ul> <p><b>Medical Record Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement year or year prior to the measurement year through:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available)</li> <li>■ A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.</li> </ul>	<p>Presentation of codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, (more)</p>	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### **DIABETES (continued)**

<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Exclusions</b>	<b>Data Source</b>
<b>EYE EXAM</b> <i>continued</i>		<p>an eye care professional reviewed the results. Alternatively, results must be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist</p> <p>OR</p> <ul style="list-style-type: none"> <li>■ a note, which may be prepared by a primary care provider, indicating the date on which the procedure was performed, and that an ophthalmoscopic exam was completed by an eye-care professional, with the results of the exam.</li> </ul>	<p>it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "X" which represents a required digit. For example, ICD-9 CM diagnosis code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p> <p><b>Electronic Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Two methods are provided to identify patients with diabetes during the measurement year, or year prior to measurement year:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available).</li> <li>■ Claim/encounter data: Patients who had two face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or year prior to the measurement year with a diagnosis of diabetes.*</li> </ul>	<p><b>Electronic Collection:</b> Exclude patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) who did not have any face-to-face encounters with the diagnosis of diabetes (see codes for diabetes above), in any setting, during the measurement year or year prior to the measurement year. Exclude patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Codes 251.8, 962.0) during the measurement year.</p> <p>Additionally, patients with bilateral foot/leg amputation (ICD-9-CM Exclusion Codes for foot exam: 896.2, 896.3, 897.6, 897).</p> <p><b>Medical Record Collection:</b> Exclude patients with a diagnosis of poly cystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement year</p>	<p>Electronic data (visit, CPT Category II Codes and pharmacy encounter data or claims) or medical record data (paper based or EHR). This measure requires the use of claims/encounter, pharmacy data, or medical record data for identification of diabetes for the denominator, and claims/encounter data, or medical record review to indicate (more)</p>
<b>FOOT EXAM</b>	Alliance/ NCOA <sup>24</sup>	<p><b>Electronic Collection:</b> Patients who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year. CPT Category II Code 2028F may be used to identify foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam)—report when any of the three components are completed).</p> <p><b>Medical Record Collection:</b> Patients who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year. Indication of a test result and date must be documented.</p>	<ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurements year on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available).</li> <li>■ Claim/encounter data: Patients who had two face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or year prior to the measurement year with a diagnosis of diabetes.*</li> </ul> <p>*Codes to identify patients with diabetes include:</p> <ul style="list-style-type: none"> <li>■ Diabetes diagnosis: ICD-9-CM Codes 250, 357.2,</li> </ul>		A-62

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### DIABETES (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>FOOT EXAM</b> <i>continued</i>			<p>362.0, 366.41, 648.0; DRGs 294, 295</p> <ul style="list-style-type: none"> <li>■ Outpatient/non-acute inpatient: CPT Codes 92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337, 993341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99496, 99499; UB-92, Revenue Codes 0118, 0128, 0148, 0158, 019X, 051X, 052X, 055X, 057X-059X, 066X, 077X, 082X-085X, 088X, 0982, 0983</li> <li>■ Acute inpatient/emergency department: CPT Codes 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99285, 99291; UB-92 Revenue Codes 010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 045X, 072X, 080X, 0981, 0987.</li> </ul> <p><b>Medical Record Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement year, or year prior to the measurement year through:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics / antihyperglycemics prescriptions (drug list is available).</li> </ul>	whether a foot exam was performed.	

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

DIABETES (continued)				
Measure	IP Owner <sup>1</sup>	Numerator	Denominator	
<b>FOOT EXAM</b> <i>continued</i>		<ul style="list-style-type: none"> <li>■ A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.</li> </ul> <p>Presentation of codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "X" which represents a required digit. For example ICD-9 CM diagnosis code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p> <p><b>Electronic Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Two methods are provided to identify patients with diabetes during the measurement year, or year prior to measurement year:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available)</li> <li>■ Claim/encounter data: Patients who had two face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or year</li> </ul>	<p><b>Exclusions</b></p> <ul style="list-style-type: none"> <li>■ A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.</li> </ul> <p>Presentation of codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "X" which represents a required digit. For example ICD-9 CM diagnosis code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p> <p><b>Electronic Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Two methods are provided to identify patients with diabetes during the measurement year, or year prior to measurement year:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available)</li> <li>■ Claim/encounter data: Patients who had two face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or year</li> </ul>	<p><b>Data Source</b></p> <ul style="list-style-type: none"> <li>■ Electronic data (visit, lab, and pharmacy encounter data or claims) or medical record data (paper based or EHR).</li> </ul> <p>These measures require the use of claims/encounter, pharmacy data or medical record data for identification of patients (more)</p>
<b>HEMOGLOBIN A1C TESTING</b>	Alliance/ NCQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> One or more HbA1c tests performed during the measurement year as identified by claim/encounter or automated laboratory data. Use any of the following codes: CPT Codes 83036, 83037; CPT Category II Codes: 3046F, 3047F or LOINC Codes: 4548-4, 4549-2, 17856-6.</p> <p><b>Medical Record Collection:</b> One or more HbA1c tests performed during the measurement year. At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result. Notation of the following in the medical record may be counted:</p>	<p><b>Exclusions</b></p> <ul style="list-style-type: none"> <li>■ A diagnosis of poly cystic ovaries (ICD-9-CM Code 256.4) who did not have any face-to-face encounters with the diagnosis of diabetes (see codes for diabetes above), in any setting, during the measurement year or year prior to the measurement year. Exclude patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Codes 251.8, 962.0) during the measurement year.</li> </ul> <p><b>Medical Record Collection:</b> Exclude patients with a diagnosis of poly cystic ovaries (ICD-9-CM Code 256.4) who did not have any face-to-face encounters with the diagnosis of diabetes (see codes for diabetes above), in any setting, during the measurement year or year prior to the measurement year. Exclude patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Codes 251.8, 962.0) during the measurement year.</p>	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### **DIABETES (continued)**

<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Exclusions</b>	<b>Data Source</b>
<b>HEMOGLOBIN A1C TESTING</b> <i>continued</i>		<ul style="list-style-type: none"> <li>■ A1c</li> <li>■ HbA1c</li> <li>■ Hemoglobin A1c</li> <li>■ Glycohemoglobin A1c</li> <li>■ HgbA1c</li> </ul>	<p>prior to the measurement year with a diagnosis of diabetes.*</p> <p>*Codes to identify patients with diabetes include:</p> <ul style="list-style-type: none"> <li>■ Diabetes diagnosis: ICD-9-CM Codes 250, 357.2, 362.0, 366.41, 648.0; DRGs 294, 295</li> <li>■ Outpatient/non-acute inpatient: CPT Codes 92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99301-99313, 99315, 99316, 99318, 99321-99338, 99331-99337, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99496, 99499, UB-92, Revenue Codes 0118, 0128, 0138, 0148, 0158, 019X, 051X, 055X, 057X-059X, 066X, 077X, 082X-085X, 088X, 0982, 0983</li> <li>■ Acute inpatient/emergency department: CPT Codes 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99285, 99291; UB-92 Revenue Codes 010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 045X, 072X, 080X, 0981, 0987.</li> </ul> <p><b>Medical Record Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement year, or year prior to the measurement year through:</p>	<p>ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year.</p> <p>Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement year.</p>	<p>with diabetes for the denominator, and claims/ encounter data, laboratory data, or medical record review for HbA1c test information.</p>

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

<b>DIABETES (continued)</b>			
<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>
<b>HEMOGLOBIN A1C TESTING</b> <i>continued</i>		<ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglyemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglyemics prescriptions (drug list is available)</li> <li>■ A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.</li> </ul>	<p>Presentation of codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "X" which represents a required digit. For example ICD-9 CM Diagnosis Code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p>

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

DIABETES (continued)				
Measure	IP Owner <sup>1</sup>	Numerator	Denominator	
<b>HEMOGLOBIN A1C MANAGEMENT</b>	Alliance/ NCQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> Using automated laboratory data, identify the <i>most recent</i> HbA1c test during the measurement year. The patient is numerator compliant if the most recent automated HbA1c level is &gt;9.0% or is missing a result or if an HbA1c test was not done during the measurement year. CPT Category II Code 3046F may also be used within the measurement year to identify an A1c level &gt;9.0%.</p> <p>The patient is <b>not</b> numerator compliant if the automated result for the most recent HbA1c test during the measurement year is ≤9.0%. CPT Category II Code 3047F may be also be used to identify an A1c level ≤9.0% (which is not numerator compliant).</p> <p><b>Note:</b> For this indicator, a lower rate indicates better performance (i.e., low rates of poor control indicate better care).</p> <p><b>Medical Record Collection:</b> The <i>most recent</i> HbA1c level (performed during the measurement year) is &gt;9.0% or is missing or was not done during the measurement year. The patient is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%. At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result.</p>	<p><b>Electronic Collection:</b> Patients 18–75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Two methods are provided to identify patients with diabetes during the measurement year, or year prior to measurement year:</p> <ul style="list-style-type: none"> <li>■ <b>Pharmacy data:</b> Patients who were dispensed insulin or oral hypoglycemics/antihyperglyemics during the measurement year or year prior to the measurement year on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglyemics prescriptions (drug list is available)</li> <li>■ <b>Claim/encounter data:</b> Patients who had two face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or year prior to the measurement year with a diagnosis of diabetes.*</li> </ul> <p><b>Medical Record Collection:</b> Exclude patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) who did not have any face-to-face encounters with the diagnosis of diabetes (see codes for diabetes above), in any setting, during the measurement year or year prior to the measurement year. Exclude patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Codes 251.8, 962.0) during the measurement year.</p> <p><b>Medical Record Collection:</b> Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement year.</p>	<p><b>Exclusions</b></p> <p><b>Data Source</b></p> <p>Electronic data (visit, lab test, lab test results and pharmacy encounter data or claims) or medical record data (paper based or EHR). These measures require the use of claims/encounter, pharmacy data or medical record data for identification of patients with diabetes for the denominator, and claims/encounter data, laboratory data, laboratory data, or medical record review for HbA1c test information.</p> <p>*Codes to identify patients with diabetes include:</p> <ul style="list-style-type: none"> <li>■ Diabetes diagnosis: ICD-9-CM Codes 250, 357.2, 362.0, 366.41, 648.0; DRGs 294, 295</li> <li>■ Outpatient/non-acute inpatient: CPT Codes 99002-99014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99301-99313, 99315, 99316, 99318, 99321-99328, 99331-</li> </ul>

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**DIABETES (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>HEMOGLOBIN A1C MANAGEMENT</b> <i>continued</i>			<p>99337, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99496, 99499; UB-92 Revenue Codes 0118, 0128, 0138, 0148, 0158, 019X, 051X, 052X, 055X, 057X-059X, 066X, 077X, 082X-085X, 088X, 0982, 0983</p> <ul style="list-style-type: none"> <li>■ Acute inpatient/emergency department: CPT Codes 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99285, 99291; UB-92 Revenue Codes 010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 045X, 072X, 080X, 0981, 0987.</li> </ul> <p><b>Medical Record Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement year, or year prior to the measurement year through:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available) <ul style="list-style-type: none"> <li>■ A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.</li> </ul> </li> </ul>	(more)	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### **DIABETES (continued)**

<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Exclusions</b>	<b>Data Source</b>
<b>HEMOGLOBIN A1C MANAGEMENT</b> <i>continued</i>			<p>Presentation of codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "X," which represents a required digit. For example ICD-9 CM Diagnosis Code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p>	<p>Patients with gestational or steroid-induced diabetes should be excluded from the denominator.</p>	<p>Physicians may use administrative data systems to identify the eligible patients.</p> <p>Administrative data sources include medical encounters, medical claims and ambulatory pharmacy records.</p> <p>Determination of patient eligibility may be based on an administrative data system, but must be supported by documentation found in the medical record.</p> <p>Numerator results (more)</p>
<b>HEMOGLOBIN A1C TEST FOR PEDIATRIC PATIENTS</b>	Alliance	<p>The number of patients in the sample who have documentation of date and result for the most recent HbA1c test during the 12-month abstraction period.</p> <p>The following are not acceptable documentation of HbA1c results: fructosamine, Hgb, hemoglobin, Hb, and Hg without reference to either "glycated," "glycosylated" and "A1" or "A1c" and findings reported on progress notes or other non-laboratory documentation.</p>	<p>A systematic sample of patients age 5-17 years old with a diagnosis of diabetes and/or notation of prescribed insulin or oral hypoglycemics/ antihyperglycemics for at least 12 months who has been under the care of the physician or physician group for at least 12 months. This is defined by documentation of a face-to-face visit for diabetes care between the physician and the patient that predates the most recent visit by at least 12 months.</p> <p>Codes and descriptions to identify a patient with a diagnosis of diabetes:</p> <p>ICD-9 Codes: 250 or 648.0. The need for diet management, insulin or oral hypoglycemic agent, report of home urine or home blood glucose testing or the presence of an insulin pump anywhere in the medical record.</p> <p>Synonyms: Insulin-dependent diabetes mellitus (IDDM), non-insulin dependent diabetes mellitus (NIDDM), Type I, Type II, DM, AODM, sugar diabetes, maturity onset diabetes, diet controlled diabetes</p>		

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

<b>DIABETES (continued)</b>			
<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>
<b>HEMOGLOBIN A1C TEST FOR PEDIATRIC PATIENTS</b> <i>continued</i>			<p>ICD-9 Code 357.2: Any mention of a diagnosis of diabetic polyneuropathy in the medical record.  <i>Synonyms:</i> Neuropathy or peripheral neuropathy, decreased or altered sensation extremity numbness or tingling, paresthesia in the lower extremity, foot ulcers, distal symmetric polyneuropathy, loss of sensation (vibration/touch) in the feet, loss of ankle reflexes, Charcot's joints, nonperforans ulcer, loss of light touch and pin prick, knife-like or burning pain of feet, sensory loss or pain in hands, or mononeuropathy.</p> <p>ICD-9 Code 362.0: Any mention of a diagnosis of diabetic retinopathy in the medical record.  <i>Synonyms:</i> Diabetic eye changes; proliferative diabetic retinopathy, new vessels on the disc (NVD), new vessels elsewhere in iris or retina, preretinal or vitreous hemorrhage, fibrosis rubesis diabetic retinal changes, macular lesion, background retinopathy, preproliferative retinopathy, venous beading/looping, large retinal blot hemorrhages, multiple cotton wool spots, multi-preintraretinal microvascular abnormalities, diabetic macular edema, non-proliferative diabetic retinopathy, microaneurysms, blot hemorrhage, hard exudates, 1-2 soft exudates.</p> <p>ICD-9 Code 366.41: Any mention of a diagnosis of diabetic cataract in the medical record.</p> <p>Descriptions to identify patients with notation of prescribed insulin or oral hypoglycemics/ antihyperglycemics:</p> <p>Insulin: Any mention of routine insulin use during the past 12 months in the medical record.</p> <p>(more)</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### DIABETES (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>HEMOGLOBIN A1C TEST FOR PEDIATRIC PATIENTS</b> <i>continued</i>			<p><i>Synonyms:</i> Any insulin, including regular insulin, insulin pump, insulin pen, 70/30, CSII (continuous subcutaneous infusion of insulin), Humalog, Humulin, Lente, Lispro, MDI (multiple daily injections), Novolin, Novolin Penfill, NPH Novo Nordisk, Semilente, Ultraente, Velosulin</p> <p>Oral hypoglycemics/antihyperglycemics: Any mention of oral hypoglycemic or antihyperglycemic use during the past 12 months in the medical record.</p> <p><i>Synonyms:</i> Acarbose, Acerohexamide, Amaryl, Chlorpropamide, Diabeta, Diabinase, Dymelor, Glipizide, Glipizide XL, Glucamide, Glucophage, Glucotrol, Glucotrol XL, Glyburide, Glynnase, Metformin, Micronase, Orinase, Osimide, Prandim (Repaglinide), Precose, Tolazamide, Tolamide, Tolbutamide, Tolinase, Troglitazone.</p>		<p>Electronic data (visit, CPT Category II Codes and pharmacy encounter data or claims) or medical record data (paper based or EHR).</p> <p>This measure requires the use of claims/encounter, pharmacy data or medical record data for identification of poly cystic ovaries on the problem list who did not (more)</p>
<b>BLOOD PRESSURE MANAGEMENT</b>	Alliance/ NCQA <sup>24</sup>	<p><i>Electronic Collection:</i> Identify the <i>most recent</i> BP reading during the measurement year. Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. The member is numerator compliant if the most recent level is &lt;140/80 mm Hg. If the result for the most recent BP reading during the measurement year is ≥140/80 mm Hg or is missing, or if a BP reading was not taken during the measurement year, the member is not numerator compliant. CPT Category II Codes 3076F (indicating most recent systolic BP &lt;140) and 3077F (indicating most recent diastolic BP &gt;80) must be used in combination in the measurement year to be numerator compliant.</p>	<p><i>Electronic Collection:</i> Exclude patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) who did not have any face-to-face encounters with the diagnosis of diabetes (see codes for diabetes above), in any setting, during the measurement year or year prior to the measurement year. Exclude patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Codes 251.8, 962.0) during the measurement year.</p> <p><b>Medical Record Collection:</b> Exclude patients with a diagnosis of poly cystic ovaries on the problem list who did not (more)</p>		

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### DIABETES (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
BLOOD PRESSURE MANAGEMENT <i>continued</i>		<p>Medical Record Collection: Patients with most recent systolic blood pressure measurement &lt;140 mm Hg and a diastolic blood pressure &lt;80 mm Hg during the measurement year, as documented through medical record review. The following steps should be followed below to determine representative BP:</p> <ul style="list-style-type: none"> <li>■ <i>Identify the most recent visit to the doctor's office or clinic</i> that occurred during the measurement year, in which a BP reading was noted.</li> <li>● To be eligible, the representative BP must have been obtained during a visit to the practitioner's office or other non-emergency outpatient facility, such as a clinic or urgent care center. Outpatient visits for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole) are not eligible</li> <li>● BP measurements obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) or at an emergency room visit are not eligible</li> <li>■ <i>Identify the lowest systolic and lowest diastolic BP reading</i> from the most recent BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.</li> </ul>	<ul style="list-style-type: none"> <li>■ Claim/encounter data: Patients who had two face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or year prior to the measurement year with a diagnosis of diabetes.*</li> <li>■ Diabetes diagnosis: ICD-9-CM Codes 250, 357.2, 362.0, 366.41, 648.0; DRGs 294, 295.</li> <li>■ Outpatient/non-acute inpatient: CPT Codes 92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99445, 99446, 99449; UB-92 Revenue Codes 0118, 0128, 0138, 0148, 0158, 019X, 051X, 052X, 055X, 057X-059X, 056X, 077X, 082X-085X, 088X, 098Z, 0983</li> <li>■ Acute inpatient/emergency department: CPT Codes 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99285, 99291; UB-92 Revenue Codes 010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 045X, 072X, 080X, 0981, 0987.</li> </ul> <p><b>Medical Record Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).</p>	<p>diabetes in the denominator, and CPT Category II Codes, or medical record review for blood pressure information.</p> <p>also have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement year.</p> <p>(more)</p>	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### **DIABETES (continued)**

<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Exclusions</b>	<b>Data Source</b>
<b>BLOOD PRESSURE MANAGEMENT</b> <i>continued</i>			<p>Patients with diabetes can be identified during the measurement year, or year prior to the measurement year through:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available).</li> <li>■ A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.</li> </ul> <p>Presentation of codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "X" which represents a required digit. For example ICD-9-CM Diagnosis Code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p>		
<b>URINE PROTEIN SCREENING</b>	Alliance/ NCQA <sup>2,4</sup>	<b>Electronic Collection:</b> Screening for nephropathy or evidence of nephropathy, as documented through administrative data. Patients who have been screened for microalbumin, or patients who have nephropathy, as demonstrated by either evidence of medical attention for nephropathy, a visit to a nephrologists or a positive urine macroalbumin test count toward the numerator.	<p><b>Electronic Collection:</b> Patients 18–75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Two methods are provided to identify patients with diabetes during the measurement year, or year prior to measurement year:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to</li> </ul>	<p><b>Electronic Collection:</b> Exclude patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) who did not have any face-to-face encounters with the diagnosis of diabetes (see codes for diabetes above), in any setting, during the measurement year or year prior to the measurement year.</p> <p>Exclude patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced</p>	<p>Electronic data (visit, lab test, lab test results and pharmacy encounter data or claims) or medical record data (paper based or EHR).</p> <p>This measure (more)</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### **DIABETES (continued)**

<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Exclusions</b>	<b>Data Source</b>
<b>URINE PROTEIN SCREENING</b> <i>continued</i>		<p>Medical attention for nephropathy; screening for nephropathy.</p> <p>A nephropathy screening test during the measurement year. Use the following codes to identify a screening test: CPT Codes: 82042, 82043, 82044, 84156; CPT Category II Codes: 3060F, 3061F or LOINC Codes 11218-5, 14956-7, 14957-5, 14958-3, 14959-1, 30000-4, 30001-2, 30003-8, 1753-3, 1754-1, 1755-8, 9318-7, 13705-9, 14585-4, 20621-9, 21059-1, 32294-1, 2887-8, 2888-6, 2889-4, 2890-2, 12842-1, 13801-6, 18373-1, 21482-5, 26801-1, 27298-9, 32209-9, 32551-4, 34366-5, 35663-4.</p> <p>Evidence of nephropathy. Documentation of nephropathy by one of the following methods during the measurement year:</p> <ul style="list-style-type: none"> <li>■ Evidence of diagnosis or treatment for nephropathy during the measurement year using the following codes: CPT Codes 36145, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512; ICD-9-CM Codes 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4, 403, 404, 405.01-405.11, 405.91, 581.81, 582.9, 583.81, 584-586, 588, 753.0, 753.1, 791.0; V-Codes V42.0, V45.1, V56, UB-92 Revenue Codes 0367, 080X, 082X-085X, 088X, DRGs 316, 317. CPT Category II Code 3066F may also be used during the measurement year to document treatment for nephropathy</li> </ul>	<p>the measurement year on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available).</p> <ul style="list-style-type: none"> <li>■ Claim/encounter data: Patients who had two face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or year prior to the measurement year with a diagnosis of diabetes.*</li> </ul> <p>*Codes to identify patients with diabetes include:</p> <ul style="list-style-type: none"> <li>■ Diabetes diagnosis: ICD-9-CM Codes 250, 357.2, 362.0, 366.41, 648.0; DRGs 294, 295.</li> <li>■ Outpatient/non-acute inpatient: CPT Codes 92002-92014, 99201-99205, 99211-99215, 99217, 99220, 99241-99245, 99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99445, 99496, 99499; UB-92 Revenue Codes 0118, 0128, 0138, 0148, 0158, 019X, 051X, 052X, 055X, 057X-059X, 066X, 077X, 082X-085X, 088X, 0982, 0983</li> <li>■ Acute inpatient/emergency department: CPT Codes 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99285, 99291; UB-92 Revenue Codes 010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134,</li> </ul>	<p>diabetes (ICD-9-CM Codes 251.8, 962.0) during the measurement year.</p> <p><b>Medical Record Collection:</b> Exclude patients with a diagnosis of poly cystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year. Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement year.</p>	<p>requires the use of claims/encounter, pharmacy data or medical record data for identification of diabetes for the denominator, and claims/encounter data, laboratory data, or medical record review for testing or medical treatment data.</p>

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### **DIABETES (continued)**

<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Exclusions</b>	<b>Data Source</b>
<b>URINE PROTEIN SCREENING</b> <i>continued</i>		<ul style="list-style-type: none"> <li>■ A nephrologist visit during the measurement year (no restriction on the diagnosis or procedure code submitted).</li> <li>■ A positive urine macroalbumin test during the measurement year, as documented by claim/encounter or automated laboratory data. Codes to identify urine microalbumin tests* (CPT Codes 81000-81003, 81005; ICD Codes 5804-0, 20454-5, 24356-8, 24357-6) and automated laboratory data must be used to confirm a positive result. "Trace" urine macroalbumin test results are not considered numerator-compliant.</li> </ul> <p>* Automated laboratory data must be used to confirm a positive result for a urine macroalbumin test identified through administrative data. CPT II Code 3062F may also be used during the measurement year to identify a positive macroalbuminuria test result was documented and reviewed.</p> <ul style="list-style-type: none"> <li>■ Evidence of ACE inhibitor/ARB therapy (or combination products—drug list available) during the measurement year. Patients who had a claim indicating therapy or who received an ambulatory prescription for therapy within the measurement year are compliant. Ambulatory prescriptions any time during the measurement year count toward this measure. Prescriptions for ACE inhibitors/ARBs that are active at the start of the measurement year may also be counted. A prescription is active if the days supply indicated on the date when the patient filled the prescription is the number of days or</li> </ul>	<p>0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 045X, 072X, 080X, 0981, 0987.</p> <p><b>Medical Record Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement year, or year prior to the measurement year through:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available).</li> <li>■ A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.</li> </ul> <p><b>Presentation of codes:</b> Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "XX" which represents a required digit. For example ICD-9 CM Diagnosis Code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p>	(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

DIABETES (continued)					
Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
URINE PROTEIN SCREENING <i>continued</i>		<p>more between the date the prescription was filled and the start of the measurement year. CPT II Code 4009F may also be used during the measurement year to identify ACE inhibitor/ARB therapy.</p> <p><b>Medical Record Collection:</b> Screening for nephropathy or evidence of nephropathy. Urine microalbumin test: At a minimum, documentation in the medical record must include a note indicating the date on which the urine microalbumin test was performed, and the result. Notation of the following may count in the medical record for urine microalbumin test:</p> <ul style="list-style-type: none"> <li>■ 24-hour urine for microalbumin</li> <li>■ Timed urine for microalbumin</li> <li>■ Spot urine for microalbumin</li> <li>■ Microalbumin/creatinine ratio</li> <li>■ 24-hour urine for total protein</li> <li>■ Random urine for protein/creatinine ratio</li> </ul> <p>Medical attention for nephropathy. Visit to a nephrologists or medical attention for nephropathy. Documentation in the medical record must include, at a minimum, a note indicating medical attention during the measurement year for:</p> <ul style="list-style-type: none"> <li>■ Diabetic nephropathy</li> <li>■ End-stage renal disease (ESRD)</li> <li>■ Chronic renal failure (CRF)</li> <li>■ Renal insufficiency</li> <li>■ Acute renal failure (ARF)</li> <li>■ Proteinuria</li> </ul>			(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

DIABETES (continued)					
Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
URINE PROTEIN SCREENING <i>continued</i>		<ul style="list-style-type: none"> <li>■ Albumuria</li> <li>■ Renal dysfunction</li> <li>■ Dialysis, hemodialysis, or peritoneal dialysis</li> </ul> <p>A positive urine macroalbumin test during the measurement year. At a minimum, documentation in the medical record must include a note indicating the date on which the test was performed, and a positive result for protein in the urine. The following may be counted in the medical record:</p> <ul style="list-style-type: none"> <li>■ Positive urinalysis (timed, spot, or random) for protein</li> <li>■ Positive urine (random, spot or timed) for protein</li> <li>■ Positive urine dipstick for protein</li> <li>■ Positive tablet reagent for urine protein</li> <li>■ Positive result for albuminuria</li> <li>■ Positive result for macroalbuminuria</li> <li>■ Positive result for proteinuria</li> <li>■ Positive result for gross proteinuria.</li> </ul> <p><i>Note:</i> "Trace" urine macroalbumin test results are not considered numerator compliant.</p> <p>Evidence of ACE inhibitor/ARB therapy during the measurement year. Documentation in the medical record must include, at minimum, a note indicating that the patient received a prescription for ACE inhibitors/ARBs on an ambulatory basis within the measurement year.</p>			(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### DIABETES (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
LIPID PROFILE	Alliance/ NCQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> An LDL-C test performed during the measurement year as identified by claim/encounter or automated laboratory data. Codes to identify LDL-C screening include: CPT Codes: 80061, 83700, 83701, 83715, 83716, 83721; LOINC codes: 2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 24331-1, 39469-2; CPT Category II Codes: 3048F, 3049F, 3050F.</p> <p><b>Medical Record Collection:</b> An ICL-C test performed during the measurement year. Documentation in the medical record must include, at a minimum, a note indicating the date on which the LDL-C test was performed and the result.</p>	<p><b>Electronic Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Two methods are provided to identify patients with diabetes during the measurement year, or year prior to measurement year:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available).</li> <li>■ Claim/encounter data: Patients who had two face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or year prior to the measurement year with a diagnosis of diabetes.</li> </ul> <p>*Codes to identify patients with diabetes include:</p> <ul style="list-style-type: none"> <li>■ Diabetes diagnosis: ICD-9-CM Codes 250, 357.2, 362.0, 366.41, 648.0; DRGs 294, 295.</li> <li>■ Outpatient/non-acute inpatient: CPT Codes 92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99301-99313, 99315, 99316, 99318, 99321-99328,</li> </ul>	<p><b>Electronic Collection:</b> Exclude patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) who did not have any face-to-face encounters with the diagnosis of diabetes (see codes for diabetes above), in any setting, during the measurement year or year prior to the measurement year.</p> <p>Exclude patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Codes 251.8, 962.0) during the measurement year.</p> <p><b>Medical Record Collection:</b> Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year.</p> <p>Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement year.</p>	<p>Electronic data (visit, lab test, and pharmacy encounter data or claims) or medical record data (paper based or EHR). This measure requires the use of claims/encounter, pharmacy data or medical record review for identification of diabetes for the denominator, and claims/encounter data, laboratory data, or medical record review for LDL test information.</p>

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### **DIABETES (continued)**

<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Exclusions</b>	<b>Data Source</b>
<b>LIPID PROFILE</b> <i>continued</i>			<p>99331-99337, 99341-99345, 99347-99350,      99384-99387, 99394-99397, 99401-99404,      99411, 99412, 99420, 99429, 99455, 99496,      99499; UB-92 Revenue Codes 0118, 0128, 0138,      0148, 0158, 019X, 051X, 052X, 055X, 057X-059X,      066X, 077X, 082X-085X, 088X, 0982, 0983</p> <ul style="list-style-type: none"> <li>■ Acute inpatient/emergency department: CPT Codes 9921-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99285, 99291; UB-92 Revenue Codes 010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 045X, 072X, 080X, 0981, 0987.</li> </ul> <p><b>Medical Record Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement year, or year prior to the measurement year through:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available).</li> <li>■ A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.</li> </ul> <p><b>Presentation of codes:</b> Unless otherwise noted, codes are stated to the minimum specificity</p>	(more)	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### DIABETES (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>LIPID PROFILE</b> <i>continued</i>	Alliance/ NCQA <sup>2,4</sup>	<p>required. For example, if a three-digit code is listed, it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "X" which represents a required digit. For example ICD-9-CM Diagnosis Code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p> <p><b>Electronic Collection:</b> Using automated laboratory data, identify the <i>most recent</i> LDL-C test during the measurement year. The patient is numerator compliant if the most recent automated LDL-C level is &lt;130 mg/dL. If the automated result for the most recent LDL-C test during the measurement year is ≥130 mg/dL or is missing, or if an LDL-C test was not done during the measurement year, the patient is not numerator compliant. CPT Category II Codes 3048F or 3049F may be used to identify LDL-C results &lt;130 mg/dL within the measurement year.</p> <p><b>Medical Record Collection:</b> The most recent LDL-C level performed during the measurement year is &lt;130mg/dL. If the result for the most recent LDL-C test during the measurement year is ≥130 mg/dL or is missing, or if an LDL-C test was not done during the measurement year, the patient is not numerator compliant. At a minimum, documentation in the medical record must include a note indicating the date on which the LDL-C test was performed, and the result.</p>	<p><b>Electronic Collection:</b> Exclude patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) who did not have any face-to-face encounters with the diagnosis of diabetes (see codes for diabetes above), in any setting, during the measurement year or year prior to the measurement year.</p> <p>Exclude patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Codes 251.8, 962.0) during the measurement year.</p> <p><b>Medical Record Collection:</b> Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year.</p> <p>Exclude patients with a diagnosis of gestational diabetes or steroid-induced diabetes on the problem list during the measurement year.</p>	<p><b>Electronic Collection:</b> Exclude patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) who did not have any face-to-face encounters with the diagnosis of diabetes (see codes for diabetes above), in any setting, during the measurement year or year prior to the measurement year.</p> <p>Exclude patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Codes 251.8, 962.0) during the measurement year.</p> <p><b>Medical Record Collection:</b> Exclude patients with a diagnosis of polycystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year.</p> <p><b>Claim/encounter data:</b> Patients who had two face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or year prior to the measurement year with a diagnosis of diabetes.*</p>	<p>Electronic data (visit, lab test, lab test results and pharmacy encounter data or claims) or medical record data (paper based or EHR).</p> <p>This measure requires the use of claims/encounter, pharmacy data or medical record review for identification of diabetes for the denominator, and claims/encounter data, laboratory data, or medical record review for LDL test information.</p>

\*Codes to identify patients with diabetes include:

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### DIABETES (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>a. Lipid Management: LDL-C &lt;130 <i>continued</i></b>		<p>LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL:</p> $(LDL-C) = (\text{total cholesterol}) - (\text{HDL}) - (\text{triglycerides}/5).$ <p>If lipoprotein (a) is measured, this calculation is:</p> $(LDL-C) = (\text{total cholesterol}) - (\text{HDL}) - (\text{triglycerides}/5) - 0.3[\text{lipoprotein (a)}].$ <p>These formulae are used when all levels are expressed in mg/dL and cannot be used if triglycerides &gt;400 mg/dL.</p>	<ul style="list-style-type: none"> <li>■ Diabetes diagnosis: ICD-9-CM Codes 250, 357.2, 362.0, 366.41, 648.0; DRGs 294, 295</li> <li>■ Outpatient/non-acute inpatient: CPT Codes 92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99301-99313, 99315, 99316, 99318, 99321-99338, 99331-99337, 99341-99345, 99247-99250, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99496, 99499, UB-92 Revenue Codes 0118, 0128, 0138, 0148, 0158, 019X, 051X, 052X, 055X, 057X-059X, 066X, 077X, 082X-085X, 088X, 0982, 0983</li> <li>■ Acute inpatient/emergency department:           <ul style="list-style-type: none"> <li>■ CPT Codes 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99285, 99291; UB-92 Revenue Codes 010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 045X, 072X, 080X, 0981, 0987.</li> </ul> </li> </ul> <p><b>Medical Record Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement year, or year prior to the measurement year through:</p> <ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglyemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available)</li> </ul>	(more)	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### DIABETES (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>a. Lipid Management: LDL-C &lt;130</b> <i>continued</i>			<ul style="list-style-type: none"> <li>■ A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.</li> </ul> <p>Presentation of codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "X" which represents a required digit. For example ICD-9 CM diagnosis code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p>		
<b>b. Lipid Management: LDL-C &lt;100</b>	Alliance/ NCQA <sup>2,4</sup>		<p><b>Electronic Collection:</b> Using automated laboratory data, identify the <i>most recent</i> LDL-C test during the measurement year. The patient is numerator compliant if the most recent automated LDL-C level is &lt;100 mg/dL. If the automated result for the most recent LDL-C test during the measurement year is ≥100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year, the patient is not numerator compliant. CPT Category II Code 3048F may be used within the measurement year to identify LDL-C results &lt;100 mg/dL.</p> <p><b>Medical Record Collection:</b> The <i>most recent</i> LDL-C level performed during the measurement year is &lt;100mg/dL. If the result for the most recent LDL-C test during the measurement year is ≥100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year, the patient is not numerator compliant. At a minimum,</p>	<p><b>Electronic Collection:</b> Exclude patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) who did not have any face-to-face encounters with the diagnosis of diabetes (see codes for diabetes above), in any setting, during the measurement year or year prior to the measurement year. Exclude patients with gestational diabetes (ICD-9-CM Code 648.8) or steroid-induced diabetes (ICD-9-CM Codes 251.8, 962.0) during the measurement year.</p> <p><b>Medical Record Collection:</b> Exclude patients with a diagnosis of poly cystic ovaries on the problem list who did not also have a diagnosis of diabetes on the problem list during the measurement year or year prior to the measurement year. Exclude patients with a diagnosis of diabetes for the denominator, and claims/encounter (more)</p>	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### **DIABETES (continued)**

<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Exclusions</b>	<b>Data Source</b>
<b>b. Lipid Management: LDL-C &lt;100</b> <i>continued</i>		<p>documentation in the medical record must include a note indicating the date on which the LDL-C test was performed, and the result.</p> <p>LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤400 mg/dL.</p> $(LDL-C) = (\text{total cholesterol}) - (\text{HDL}) - (\text{triglycerides}/5).$ <p>If lipoprotein (a) is measured, this calculation is:</p> $(LDL-C) = (\text{total cholesterol}) - (\text{HDL}) - (\text{triglycerides}/5) - 0.3[\text{lipoprotein (a)}].$ <p>These formulae are used when all levels are expressed in mg/dL and cannot be used if triglycerides &gt;400 mg/dL.</p>	<p>in an acute inpatient or emergency room setting during the measurement year or year prior to the measurement year with a diagnosis of diabetes.*</p> <ul style="list-style-type: none"> <li>■ Codes to identify patients with diabetes include:</li> <li>■ Diabetes diagnosis: ICD-9-CM Codes 250, 357.2, 362.0, 366.41, 648.0; DRGs 294, 295</li> <li>■ Outpatient/non-acute inpatient: CPT Codes 92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99496, 99499; UB-92 Revenue Codes 0118, 0128, 0138, 0148, 0158, 019X, 051X, 052X, 055X, 057X-059X, 066X, 077X, 082X-085X, 088X, 0982, 0983</li> <li>■ Acute inpatient/emergency department:</li> <li>■ CPT Codes 99221-99223, 99231-99233, 99238-99239, 99251-99255, 99261-99263, 99281-99285, 99291; UB-92 Revenue Codes 010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 045X, 072X, 080X, 0981, 0987.</li> </ul> <p><b>Medical Record Collection:</b> Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes can be identified during the measurement year or year prior to the measurement year through:</p>	<p>gestational diabetes or steroid-induced diabetes on the problem list during the measurement year.</p>	<p>data, laboratory data, or medical record review for HbA1c test information.</p>

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

<b>DIABETES (continued)</b>			
<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>
			<b>Exclusions</b>
<b>b. Lipid Management: LDL-C &lt;100 <i>continued</i></b>			<ul style="list-style-type: none"> <li>■ Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglyemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglyemics prescriptions (drug list is available).</li> <li>■ A diagnosis of diabetes on the problem list or at least two visits with diabetes listed as a diagnosis.</li> </ul> <p>Presentation of codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four- or five-digit code. When necessary, a code may be specified with an "XX", which represents a required digit. For example, ICD-9 CM Diagnosis Code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p>

(more)

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## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

HEART DISEASE					
Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CORONARY ARTERY DISEASE: SYMPTOM AND ACTIVITY ASSESSMENT</b>	AMA PCP <sup>2,3/</sup> ACC/AHA	<p>Patients evaluated for both level of activity and anginal symptoms during one or more office visits.</p> <p>Medical record must include documentation of the patient's level of activity and anginal symptoms</p> <p>AND/OR</p> <p>Grading of angina by the Canadian Cardiovascular Society Classification System</p> <p>AND/OR</p> <p>The patient completed a symptom and/or activity questionnaire (e.g., Seattle Angina Questionnaire)</p> <p>OR</p> <p>CPT II Code: 1002F Anginal symptoms and level of activity assessed.</p>	<p>All patients with CAD ≥18 years of age.</p> <p>Patient selection: ICD-9-CM Codes for CAD: 414.00-414.07, 414.8, 414.9, 410.00-410.92, 412, 411.0-411.89, 413.0-413.9, V45.81, V45.82</p> <p>OR</p> <p>CPT Diagnosis Codes: 92980-92982, 92984, 92995, 92996, 33140, 33510-33514, 33516-33519, 33521-33523, 33533, 33536</p> <p>AND</p> <p>CPT Codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404</p> <p>AND</p> <p>Patient's age is ≥18 years.</p>	<p>None.</p>	<p>EHRS, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.</p>
<b>CORONARY ARTERY DISEASE: ANGIOTENSIN CONVERTING ENZYME INHIBITOR/ ANGIOTENSIN RECEPTOR BLOCKER THERAPY</b>	AMA PCP <sup>2,3/</sup> ACC/AHA	<p>Patients who were prescribed ACE inhibitor or ARB therapy (drug list available at <a href="http://www.ama-assn.org/ama/pub/category/4837.html">www.ama-assn.org/ama/pub/category/4837.html</a>)</p> <p>OR</p> <p>CPT II Code: 4009F: ACE inhibitor or ARB therapy prescribed.</p>	<p>All patients with CAD ≥18 years of age who also have diabetes and/or LVSD.</p> <p>Patient selection: ICD-9-CM Codes for CAD: 414.00-414.07, 414.8, 414.9, 410.00-410.92, 412, 411.0-411.89, 413.0-413.9, V45.81, V45.82</p> <p>OR</p> <p>CPT Codes: 92980-92982, 92984, 92995, 92996, 33140, 33510-33514, 33516-33519, 33521-33523, 33533-33536</p> <p>AND</p> <p>ICD-9-CM Codes for diabetes: 250.00-250.93, 357.2, 362.01-362.07, 366.41, 648.00-648.04</p> <p>OR</p> <p>With an active antidiabetic medication* prescribed (drug list available)</p>	<p>Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy:</p> <ul style="list-style-type: none"> <li>■ Allergy or intolerance to ACE inhibitor or ARB</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ ACE inhibitor contraindications including angioedema, anuria renal failure, moderate or severe aortic stenosis or pregnancy [ICD-9-CM Exclusion Codes: 440.1, V56.0, V56.8, 39.95, 54.98, 788.5, 586, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 584.5-584.9, 585.5, 585.6, 395.0, 395.2, 396.0, 396.2, 396.8, 425.1, 747.22, V22.0-V23.9, 277.6]</li> </ul>	<p>EHRS, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.</p>

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CORONARY ARTERY DISEASE:</b> <b>ANGIOTENSIN CONVERTING ENZYME INHIBITOR/ ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY</b> <i>continued</i>			<p><i>OR</i></p> <p>CPT Procedure Codes for testing LVSD: 78414, 78468, 78472, 78473, 78480, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 93353</p> <p><i>AND</i></p> <p>Additional individual medical record review must be completed to identify patients who had documentation of an ejection fraction &lt;40% (use most recent value)</p> <p><i>OR</i></p> <p>CPT II Codes: 3021F Left ventricular ejection fraction (LVEF) &lt;40% or documentation of moderately or severely depressed left ventricular systolic function</p> <p><i>AND</i></p> <p>Patient's age is ≥18 years.</p>	<ul style="list-style-type: none"> <li>■ Other medical reason documented by the practitioner for not prescribing ACE inhibitor or ARB therapy</li> </ul> <p><i>OR</i></p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier 4009F 1P Other patient reason (e.g., economic, social, religious)</li> </ul> <p><i>OR</i></p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier 4009F 2P Other system reason for not prescribing ACE inhibitor or ARB therapy;</li> </ul> <p><i>OR</i></p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier 4009F 3P.</li> </ul>	<p>EHRS, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.</p> <p>(more)</p>
<b>CORONARY ARTERY DISEASE:</b> <b>ANTIPLATELET THERAPY</b>	CMS/AMA PCPI <sup>2,3</sup> / ACC/AHA	<p>Patients who were prescribed antiplatelet therapy (aspirin, clopidogrel or combination of aspirin and dipyridamole) (drug list available at <a href="http://www.ama-assn.org/ama/pub/category/4837.html">www.ama-assn.org/ama/pub/category/4837.html</a>)</p> <p><i>OR</i></p> <p>CPT II Code: 4011F Oral antiplatelet therapy prescribed.</p>	<p>All patients with CAD ≥18 years of age. Patient selection: ICD-9-CM Codes for CAD: 414.00-414.07, 414.8, 414.9, 410.00-410.92, 412, 411.0-411.89, 413.0-413.9, V45.81, V45.82</p> <p><i>OR</i></p> <p>CPT Diagnosis Codes: 92980-92982, 92984, 92995, 92996, 33140, 33510-33514, 33516-33519, 33521-33523, 33533-33536</p> <p><i>AND</i></p> <p>CPT Codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404</p>	<p>Documentation of medical reason(s) for not prescribing antiplatelet therapy:</p> <ul style="list-style-type: none"> <li>■ Active bleeding in the previous six months, which required hospitalization(s) or transfusion(s)</li> </ul> <p><i>OR</i></p> <ul style="list-style-type: none"> <li>■ Aspirin/clopidogrel allergy/intolerance ICD-9-CM Exclusion Codes: 995.0 and E935.3, 995.1 and E935.3, 995.2 and E935.3, 995.0, and E934.8, 995.1 and E934.8, 995.2 and E934.8</li> </ul> <p><i>OR</i></p>	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CORONARY ARTERY DISEASE: ANTIPLATELET THERAPY</b> <i>continued</i>			<p><i>If ND</i> Patient's age is <math>\geq 18</math> years.</p> <ul style="list-style-type: none"> <li>■ Other medical reason(s) documented by the practitioner for not prescribing antiplatelet therapy</li> <li>OR</li> <li>■ CPT II Code w/modifier: 4011F 1P Documentation of patient reason(s) (e.g., economic, social, religious)</li> <li>OR</li> <li>CPT II Code w/modifier: 4011F 2P Documentation of system reason(s) documented by the practitioner for not prescribing antiplatelet therapy</li> <li>OR</li> <li>CPT II Code w/modifier 4011F 3P:</li> </ul>	<ul style="list-style-type: none"> <li>Exclude patient self-report.</li> </ul>	<p>Physicians may use administrative data systems to identify eligible patients.</p> <p>Administrative data sources include medical encounters, medical claims and ambulatory pharmacy records.</p> <p>Determination of patient eligibility may be based on (more)</p>
<b>ISCHEMIC VASCULAR DISEASE (IVD): USE OF ASPIRIN OR ANOTHER ANTITHROMBOTIC</b>	NCQA <sup>2,4</sup>	The number of patients who have documentation of use of aspirin or another antithrombotic during the 12-month measurement period.  Documentation in the medical record must include, at a minimum, a note indicating the date on which aspirin or another antithrombotic was prescribed or documentation of prescription from another treating physician.	A systematic sample of patients age 18 years and older with a diagnosis of ischemic vascular disease (IVD) for at least 12 months, who have been under the care of the physician or physician group for IVD for at least 12 months (this is defined by documentation of face-to-face visit for IVD care between the physician and the patient that predates the most recent IVD visit by at least 12 months).  Codes to identify a patient with a diagnosis of ischemic vascular disease: ICD-9: 411, 413, 414, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 444, 445 DRG: 140, 559.  If using health plan administrative claims to identify the eligible population and then attributing to physicians, use the following denominator specifications:  Discharged alive for AMI, CABG or PTCA on or between 1/1-11/1 of the year prior to the measurement year or at one outpatient or acute		

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ISCHEMIC VASCULAR DISEASE (IVD): USE OF ASPIRIN OR ANOTHER ANTITHROM- BOTIC</b> <i>continued</i>			<p>Inpatient during the measurement year and year prior to the measurement year.</p> <p>AMI: ICD-9:410.X1, DRG: 121, 122, 516</p> <p>PTCA: CPT: 331140, 92980-92982, 92984, 92995, 92996, ICD-9:00.66, 36.01, 36.02, 36.05, 36.06, 36.07, 36.09, DRG: 516, 517, 526, 527, 555-558</p> <p>CABG: CPT: 33510-33514, 33516-33519, 33521-33523, 33533-33536, 35600, 33572, HCPCS: S2205-S2209, ICD-9:36.1, 36.2, DRG: 106, 107, 109, 547-550.</p> <p>Codes to identify a patient with a diagnosis of ischemic vascular disease: ICD-9:411, 413, 414.0, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 444, 445 DRG: 140, 559.</p> <p>Outpatient codes: CPT: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499, UB-92: 051X, 0520-0523, 0526-0529, 057X-059X, 077X, 0982, 0983.</p> <p>Acute inpatient: CPT: 99221-99223, 99231-99233, 99238, 99239, 99251, 99255, 99261-99263, 99291, UB-92: 010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 072X, 0987.</p>	<p>Presentation of codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four- or five-digit code. When necessary, a code may be specified with an "X," which represents a required digit. For example, ICD-9 CM Diagnosis Code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p> <p>(more)</p>	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CORONARY ARTERY DISEASE—BETA BLOCKER THERAPY: PRIOR MYOCARDIAL INFARCTION</b>	AMA PPI <sup>2,3</sup> /ACC/AHA	<p>Patients who were prescribed beta blocker therapy (drug list available at <a href="http://www.ama-assn.org/ama/pub/category/4837.html">www.ama-assn.org/ama/pub/category/4837.html</a>)</p> <p>OR</p> <p>CPT II Code 4006F: Beta blocker therapy prescribed.</p>	<p>All patients with CAD who also have prior MI at any time <math>\geq 18</math> years of age.</p> <p>Patient selection: ICD-9-CM Codes for CAD: 414.00-414.07, 414.8, 414.9, 410.00-410.92, 412, 411.0-411.89, 413.0-413.9, V45.81, V45.82</p> <p>OR</p> <p>CPT Codes: 92980-92982, 92984, 92995, 92996, 33140, 333510-333514, 333516-333519, 333521-333523, 33333-33336</p> <p>AND</p> <p>ICD-9-CM Codes for MI: 410.00-410.92, 412</p> <p>AND</p> <p>Patient's age is <math>\geq 18</math> years.</p>	<p>Documentation of medical reason(s) for not prescribing beta blocker therapy:</p> <ul style="list-style-type: none"> <li>■ Documentation of bradycardia &lt;50 bpm (without beta blocker therapy) on two consecutive readings, history of Class IV (congestive) heart failure, history of second- or third-degree atrioventricular (AV) block without permanent pacemaker  CD-9-CM Exclusion Codes: 493.00-493-92, 458.0, 458.1, 458.21, 458.29, 458.8, 458.9, 426.0 without V45.01, 426.12 without V45.01, 427.81, 427.89 without V45.01, 427.81, 427.89</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ Other medical reason(s) documented by the practitioner for not prescribing beta blocker therapy</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ CPT II Code with modifier: 4006F 1P: Documentation of patient reason(s) (e.g., economic, social, religious)</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ CPT II Code with modifier: 4006F 2P: Documentation of system reason(s) for not prescribing beta blocker therapy</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier 4006F 3P:</li> </ul>	<p>EHRS, retrospective paper medical records, Prospective flowsheet, administrative data using CPT II Codes.</p>

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ACUTE MYOCARDIAL INFARCTION: PERSISTENCE OF BETA BLOCKER TREATMENT AFTER A HEART ATTACK</b>	NQCA <sup>2,4</sup>	<p><b>Electronic Collection:</b> The number of patients in the denominator population whose day's supply of beta blockers dispensed is <math>\geq 135</math> days in the 180 days following discharge. Persistence of treatment for this measure is defined as at least 75% of the days' supply filled.</p> <p>To account for patients who are on beta blockers prior to admission, factor those prescriptions into adherence rates if the actual treatment days fall within the 180 days following discharge.</p> <p>An updated list of NDC Codes for beta-blockers is posted to the NQCA web site, <a href="http://www.nqca.org">www.nqca.org</a>.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator:</b> The number of patients in the denominator population whose day's supply of beta blockers prescribed is <math>\geq 135</math> days in the 180 days following discharge. Persistence of treatment for this measure is defined as at least 75% of the days' supply filled.</p> <p>To account for patients who are on beta blockers prior to admission, factor those prescriptions into adherence rates if the actual treatment days fall within the 180 days following discharge.</p>	<p><b>Electronic Collection:</b> All patients aged 35 and older as of December 31 of the measurement year, discharged alive from an acute inpatient setting with an AMI between July 1 of the year prior to the measurement year through June 30 of the measurement year.</p> <p>If a patient has more than one episode of AMI from July 1 of the year prior to the measurement year through June 30 of the measurement year, include only the first discharge and use the codes listed identify AMIs.</p> <p>Codes to identify AMIs: ICD-9-CM Code: 410X1 DRG: 121, 122, 516, 526.</p> <p>Transfers to acute facilities: Include hospitalizations in which the patient was transferred directly to another <i>acute care facility</i> for any diagnosis. Count the discharge from the subsequent, not the initial, acute inpatient facility. The discharge date from the facility to which the patient was transferred must occur on or before June 30 of the measurement year.</p> <p>Transfers to non-acute facilities: Exclude from the denominator hospitalizations in which the patient was transferred directly to a non-acute care facility for any diagnosis.</p> <p>Readmissions: If the patient is readmitted to an acute or non-acute care facility for any diagnosis, include the patient in the denominator and use the discharge date from the original hospitalization.</p>	<p>Exclude patients who are identified as having a contraindication to beta blocker therapy or previous adverse reaction to beta blocker therapy. Look as far back as possible in the patient's history through either administrative data or medical record review for evidence of contraindication or a previous adverse reaction to beta-blocker therapy.</p> <p>Codes to identify contraindications to beta-blockers:</p> <p>History of asthma: prescription: inhaled corticosteroids, ICD-9: 493</p> <p>Hypotension: 458</p> <p>Heart block &gt;1 degree: 426.0, 426.12, 426.13, 426.2, 426.4, 426.51, 426.52, 426.54, 426.75 sinus bradycardia: 427.81 COPD: 491.2, 496, 506.4.</p>	<p>Visit and pharmacy encounter data or claims. Electronic data may be supplemented with medical record data.</p>

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ACUTE MYOCARDIAL INFARCTION: PERSISTENCE OF BETA BLOCKER TREATMENT AFTER A HEART ATTACK</b> <i>continued</i>		Documentation in medical record must include, at a minimum, a note indicating that the patient received a prescription for beta blockers within the timeframe specified.	<p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Denominator:</b> All patients aged 35 and older as of December 31 of the measurement year, discharged alive from an acute inpatient setting with an AMI between July 1 of the year prior to the measurement year through June 30 of the measurement year.</p> <p>If a patient has more than one episode of AMI from July 1 of the year prior to the measurement year through June 30 of the measurement year, include only the first discharge.</p> <p><b>Transfers to acute facilities:</b> Include hospitalizations in which the patient was transferred directly to another <i>acute care facility</i> for any diagnosis. Count the discharge from the subsequent, not the initial, acute inpatient facility. The discharge date from the facility to which the patient was transferred must occur on or before June 30 of the measurement year.</p> <p><b>Transfers to non-acute facilities:</b> Exclude from the denominator hospitalizations in which the patient was transferred directly to a non-acute care facility for any diagnosis.</p> <p><b>Readmissions:</b> If the patient is readmitted to an acute or non-acute care facility for any diagnosis,</p>	(more)	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ACUTE MYOCARDIAL INFARCTION: PERSISTENCE OF BETA BLOCKER TREATMENT AFTER A HEART ATTACK</b> <i>continued</i>			<p>include the patient in the denominator and use the discharge date from the original hospitalization.</p> <p><b>Denominator (patients for inclusion):</b> A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims or other codified encounter data should be used to identify patients who have had an acute myocardial infarction in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p>		<p>Visit and pharmacy encounter data or claims. Electronic data may be supplemented with medical record data.</p>
<b>CORONARY ARTERY DISEASE: BETA BLOCKER TREATMENT AFTER A HEART ATTACK</b>	NQO <sup>2,4</sup>	<p><b>Electronic Collection:</b> Patients who have a claim indicating beta blocker therapy or who received an ambulatory prescription for beta blockers within seven days (inclusive) after discharge. Prescriptions rendered on an <i>ambulatory</i> basis any time while the patient is hospitalized for AMI through the seventh day after discharge count toward this measure. If unable to determine if the prescription was rendered on an inpatient or ambulatory basis, prescriptions rendered after discharge may only count. To account for patients who are on beta blockers prior to admission, count prescriptions for beta blockers that are active at the time of admission.</p> <p>A prescription is considered active if the "days supply" indicated on the date the patient filled the</p>	<p><b>Electronic Collection:</b> Patients 35 of age and older as of December 31 of the measurement year who are discharged alive from an inpatient setting with an AMI from January 1 to December 24 of the measurement year. If a patient has more than one episode of AMI from January 1–December 24 of the measurement year, only include the first eligible discharge. Use the following codes to identify AMIs:</p> <p>ICD-9-CM Code: 410.X1; DRGs: 121, 122, 516, 526.</p> <p>Transfers to acute facilities: Include hospitalizations in which the patient was transferred directly to another acute care facility for any diagnosis. The discharge date from the facility to which the patient was transferred must occur on or before December 24 of the measurement year.</p>	<p>Exclude from the denominator patients who are identified as having a contraindication to beta blocker therapy or previous adverse reaction (i.e., intolerance) to beta blocker therapy. Look-backs as far as possible in the patient's history through either administrative data or medical record review for evidence of a contraindication or previous adverse reaction to beta blocker therapy. Any of the following codes may be used:</p> <p>History of asthma (prescription: Inhaled corticosteroids): ICD-9: 493 Hypotension: ICD-9: 458</p>	(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CORONARY ARTERY DISEASE: BETA BLOCKER TREATMENT AFTER A HEART ATTACK</b> <i>continued</i>		<p>prescription is the number of days or more between the date the prescription was filled and the relevant admission date.</p> <p><b>Transfers:</b> If a patient was directly transferred to another acute facility, the prescription is active on the date of admission for the initial inpatient stay for AMI or that the patient received a beta blocker prescription within seven days after the discharge from the facility to which the patient was transferred.</p> <p>An updated list of NDC Codes for beta blockers is posted to the NCQA web site, <a href="http://www.ncqa.org">www.ncqa.org</a>. Codes to identify beta blocker therapy prescribed include CPT Category II Code: 4006F.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p>A systematic sample of patients age 35 years and older as of December 31 of the measurement year who are discharged alive from an inpatient setting with an AMI from January 1 to December 24 of the measurement year. If a patient has more than one episode of AMI from January 1 to December 24 of the measurement year, only include the first eligible discharge.</p> <p><b>Transfers to acute facilities:</b> Include hospitalizations in which the patient was transferred directly to another acute care facility for any diagnosis. The discharge date from the facility to which the patient was transferred must occur on or before December 24 of the measurement year.</p>	<p>Transfers to non-acute facilities; Exclude from the denominator hospitalizations in which the patient was transferred directly to a non-acute care facility for any diagnosis.</p> <p><b>Readmissions:</b> Exclude from the denominator hospitalizations in which the patient was readmitted to an acute or non-acute care facility for any diagnosis within seven days after discharge, because tracking the patient between admissions is not deemed feasible.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p>A systematic sample of patients age 35 years and older as of December 31 of the measurement year who are discharged alive from an inpatient setting with an AMI from January 1 to December 24 of the measurement year. If a patient has more than one episode of AMI from January 1 to December 24 of the measurement year, only include the first eligible discharge.</p> <p><b>Transfers to acute facilities:</b> Include hospitalizations in which the patient was transferred directly to another acute care facility for any diagnosis. The discharge date from the facility to which the patient was transferred must occur on or before December 24 of the measurement year.</p>	<p>Heart block &gt;1 degree: ICD-9: 426.0, 426.12, 426.13, 426.2, 426.4, 426.51, 426.54, 426.7</p> <p>Sinus bradycardia: ICD-9: 427.81</p> <p>COPD: ICD-9: 491.2, 496, 506.4.</p>	(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CORONARY ARTERY DISEASE: BETA BLOCKER TREATMENT AFTER A HEART ATTACK</b> <i>continued</i>		To account for patients who are on beta blockers prior to admission, count prescriptions for beta blockers that are active at the time of admission. Documentation in medical record must include, at a minimum, a note indicating that the patient received a prescription for beta blockers within the timeframe specified.	Transfers to non-acute facilities; Exclude from the denominator hospitalizations in which the patient was transferred directly to a non-acute care facility for any diagnosis.  Readmissions. Exclude from the denominator hospitalizations in which the patient was readmitted to an acute or non-acute care facility for any diagnosis within seven days after discharge, because tracking the patient between admissions is not deemed feasible.  <b>Denominator (patients for inclusion):</b> A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.		

(more)

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## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source	
<b>ISCHEMIC VASCULAR DISEASE: BLOOD PRESSURE CONTROL</b>	NCQA <sup>2,4</sup>	Number of patients who, at their most recent blood pressure reading during the 12-month measurement period, had a blood pressure result of <140/90 mm HG.	A systematic sample of patients, age 18 years and older with a diagnosis of ischemic vascular disease (IVD) for at least 12 months, who have been under the care of the physician or physician group for IVD for at least 12 months (this is defined by documentation of a face-to-face visit for IVD care between the physician and the patient that predates the most recent IVD visit by at least 12 months). Codes to identify a patient with a diagnosis of ischemic vascular disease: ICD-9:411, 413, 4140, 4148, 4149, 429.2, 433-434, 440.1, 440.2, 444, 445 DRG: 140, 559.  If using health plan administrative claims to identify the eligible population and then attributing to physicians, use the following denominator specifications: Discharged alive for AMI, CABG or PTCA on or between 1/1-11/1 of the year prior to the measurement year or at one outpatient or acute inpatient during the measurement year and year prior to the measurement year.  AMI: ICD-9: 410.X1, DRG: 121, 122, 516 PTCA: CPT: 33140, 92980-92982, 92984, 92995, 92996, ICD-9:00.66, 36.01, 36.02, 36.05, 36.06, 36.07, 36.09, DRG: 516, 517, 526, 527, 555-558 CABG: CPT: 33510-33514, 33516-33519, 33521-33523, 33533-33536, 35600, 33572, HCPCS: S2205-S2209, ICD-9:36.1, 36.2, DRG: 106, 107, 109, 547-550. Codes to identify a patient with a diagnosis of ischemic vascular disease: ICD-9:411, 413, 4140, 4148, 4149, 429.2, 433-434, 440.1, 440.2, 444, 445 DRG: 140, 559.  Outpatient codes: CPT: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345,	Denominator (patients for inclusion): A sample should be determined using the most accurate data available. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator.  BPs that are self-reported by the patient (e.g., home and health-fair BPs reported by the patient) are not eligible.	Visit and pharmacy encounter data or claims. Electronic data may be supplemented with medical record data.	(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ISCHEMIC VASCULAR DISEASE: BLOOD PRESSURE CONTROL</b> <i>continued</i>			<p>99247-99250, 99284-99287, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499, UB-92-051X, 0520-0523, 0526-0529, 057X-059X, 077X, 0982, 0983.</p> <p>Acute inpatient: CPT: 99221-99223, 99231-99233, 99238, 99239, 99251, 99255, 99261-99263, 99291, UB-92-010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 072X, 0987.</p> <p>Presentation of codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "X", which represents a required digit. For example ICD-9 CM Diagnosis Code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p>		<p>EHRS, retrospective paper medical records, prospective flowsheet, administrative</p> <p>data using CPT II Codes.</p>
<b>CORONARY ARTERY DISEASE: DRUG THERAPY FOR LOWERING LDL-CHOLESTEROL</b>	AMA PCPI/ ACC/AHA <sup>2,3</sup>	<p>Patients who were prescribed lipid-lowering therapy (based on current ACC/AHA guidelines).</p> <p>Drug list is available.</p> <p>Or</p> <p>CPT II Code: 4002F Statin therapy prescribed.</p>	<p>All patients with CAD <math>\geq</math>18 years of age.</p> <p>Patient selection: ICD-9-CM Codes for CAD: 414.00-41407, 414.8, 414.9, 410.00-410.92, 412, 411.0-411.89, 413.0-413.9, V45.81, V45.82</p> <p>Or</p> <p>CPT Diagnosis Codes: 92980-92982, 92984, 92995, 92996, 33140, 33510-33514, 33516-33519, 33521-33523, 33533-33536</p> <p>AND</p> <p>Patient's age is <math>\geq</math>18 years.</p>	<p>Documentation of medical reason(s) for not prescribing lipid-lowering therapy:</p> <ul style="list-style-type: none"> <li>■ Lipid-lowering drug therapy allergy/ intolerance ICD-9-CM Exclusion Codes: 995.0 and E942.2, 995.1 and E942.2, 995.27 and E942.2, 995.29 and E942.2</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ LOINC (LN) Codes with associated LDL values &lt;130 mg/dL: 12773-8, 13457-7, 18262-6, 2089-1, 22748-8, 24331-1, 39469-2 AND LDL &lt;130 mg/dL</li> </ul> <p>Or</p>	(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**HEART DISEASE (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CORONARY ARTERY DISEASE: DRUG THERAPY FOR LOWERING LDL-CHOLESTEROL</b> <i>continued</i>			<ul style="list-style-type: none"> <li>■ CPT (C4) codes with associated LDL values &lt;130 mg/dL: 80061, 83700, 83701, 83704, 83721 AND LDL-C &lt;130 mg/dL</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ Other medical reason(s) documented by the practitioner for not prescribing lipid-lowering therapy</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier: 4002F 1P</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ Documentation of patient reason(s) (e.g., economic, social, religious)</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier: 4002F 2P</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ Documentation of system reason(s) (e.g., resources to perform service not available)</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier: 4002F 3P.</li> </ul>	<ul style="list-style-type: none"> <li>■ CPT (C4) codes with associated LDL values &lt;130 mg/dL: 80061, 83700, 83701, 83704, 83721 AND LDL-C &lt;130 mg/dL</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ Other medical reason(s) documented by the practitioner for not prescribing lipid-lowering therapy</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier: 4002F 1P</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ Documentation of patient reason(s) (e.g., economic, social, religious)</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier: 4002F 2P</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ Documentation of system reason(s) (e.g., resources to perform service not available)</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier: 4002F 3P.</li> </ul>	<p>Physicians may use administrative data systems to identify eligible patients. Administrative data sources (more)</p>
<b>ISCHEMIC VASCULAR DISEASE: COMPLETE LIPID PROFILE AND LDL CONTROL &lt;100</b>	NCOA <sup>2,4</sup>	<b>Numerator a:</b> Number of patients with a full lipid profile completed during the 12-month measurement period with date of each component of the profile documented. <ul style="list-style-type: none"> <li>■ Identify the most recent visit to the doctor's office or clinic that occurred during the measurement year (but after the diagnosis of IVD was made) in which a full lipid profile was documented</li> </ul>	A systematic sample of patients, age 18 years and older with a diagnosis of ischemic vascular disease (IVD) for at least 12 months, who have been under the care of the physician or physician group for IVD for at least 12 months (this is defined by documentation of a face-to-face visit for IVD care between the physician and the patient that predates the most recent IVD visit by at least 12 months).	Exclude patient self-report or self-monitoring, LDL to HDL ratio, and findings reported on progress notes or other non-laboratory documentation.	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ISCHEMIC VASCULAR DISEASE: COMPLETE LIPID PROFILE AND LDL CONTROL &lt;100</b> <i>continued</i>		<ul style="list-style-type: none"> <li>■ Each component of the lipid profile must be noted with the date of the laboratory test and results.</li> </ul> <p><b>Numerator b:</b> Number of patients with an LDL completed during the 12-month abstraction period with date and LDL less than 100 mg/dl documented.</p> <p>CPT II Codes for compliance: 3048F CPT II Codes for non-compliance: 3049F, 3050F.</p>	<p>Codes to identify a patient with a diagnosis of ischemic vascular disease: ICD-9: 411, 413, 4140, 4148, 4149, 4292, 4334, 4401, 4402, 444, 445 DRG: 140, 559.</p> <p>If using health plan administrative claims to identify the eligible population and then attributing to physicians, use the following denominator specifications:</p> <p>Discharged alive for AMI, CABG, or PTCA on or between 1/1-11/1 of the year prior to the measurement year or at one outpatient or acute inpatient during the measurement year and year prior to the measurement year.</p> <p>AMI: ICD-9: 410.X1, DRG: 121, 122, 516</p> <p>PTCA: CPT: 33140, 92980-92982, 92984, 92995, 92996, ICD-9: 00.66, 36.01, 36.02, 36.05, 36.06, 36.07, 36.09, DRG: 516, 517, 526, 527, 555-558</p> <p>CABG: CPT: 33510-33514, 33516-33519, 33521-33523, 33533-33536, 35600, 33572, HCPCS: S2205-S2209, ICD-9: 36.1, 36.2, DRG: 106, 107, 109, 547-550.</p> <p>Codes to identify a patient with a diagnosis of ischemic vascular disease: ICD-9: 411, 413, 4140, 4148, 4149, 4292, 433434, 4401, 4402, 444, 445 DRG: 140, 559.</p> <p>Outpatient codes: CPT: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499, UB-92: 051X, 0520-0523, 0526-0529, 057X-059X, 077X, 098Z, 0983.</p>		(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ISCHEMIC VASCULAR DISEASE: COMPLETE LIPID PROFILE AND LDL CONTROL &lt;100</b> <i>continued</i>			<p>Acute inpatient: CPT: 99221-99223, 99231-99233, 99238, 99239, 99251, 99255, 99261-99263, 99291, UB-92-010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016X, 020X-022X, 072X, 0987.</p> <p>Presentation of codes: Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three-digit code is listed, it is valid as a three-, four-, or five-digit code. When necessary, a code may be specified with an "XX" which represents a required digit. For example ICD-9 CM Diagnosis Code 640.0X means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.</p>		<p>Numerator exclusion: Members contraindicated to aspirin therapy are excluded from the "Aspirin Usage" component of the measure.</p> <p>Denominator exclusions: Members can be validly excluded from the sample for the following reasons during the measurement year: member died, resident in nursing home, or hospice. Sampling error member does not have CAD.</p>
<b>CORONARY ARTERY DISEASE: OPTIMALLY MANAGED MODIFIABLE RISK FACTORS</b>	HealthPartners	<p>All members from the denominator who reach treatment targets* for all numerator components:</p> <ul style="list-style-type: none"> <li>■ Low-Density Lipoprotein (LDL) Screening—Coronary artery disease (CAD) population who had an LDL during the measurement year or the year prior to the measurement year with a level less than 100 for the most recent screening.</li> <li>■ Tobacco Non-User—CAD population with documented non-smoking status.</li> <li>■ Blood Pressure Control—CAD population whose blood pressure is in control less than 140/90 during the measurement year.</li> <li>■ Aspirin Usage—CAD population eligible for aspirin use who were on aspirin therapy.</li> </ul>	<p>Members between 18 and 75 years of age as of December 31 of the reporting year, who were continually enrolled with not more than 1 month break in coverage and have a diagnosis of coronary artery disease (CAD).*</p> <p>*CAD diagnosis: 410.XX Acute Myocardial Infarction (AMI), 411.XX Post Myocardial Infarction Syndrome, 412.01d AMI, 413.XX Angina Pectoris, 414.0X Coronary Atherosclerosis, 414.10 Aneurysm of Heart Wall, 414.8 Other Chronic Ischemic Heart Disease (IHD), 414.9 Chronic IHD.</p>	<p>Numerator exclusion: Members contraindicated to aspirin therapy are excluded from the "Aspirin Usage" component of the measure.</p> <p>Denominator exclusions: Members can be validly excluded from the sample for the following reasons during the measurement year: member died, resident in nursing home, or hospice. Sampling error member does not have CAD.</p>	(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>HEART FAILURE: ASSESSMENT OF ACTIVITY LEVEL</b>	AMA PCPI/ACC/AHA <sup>2,3</sup>	<p>Patient visits with assessment of current level of activity <i>OR</i> documentation of standardized scale or completion of assessment tool.*</p> <p>Medical record must include: Documentation of the current level of activity</p> <p><i>OR</i></p> <p>Documentation that a standardized scale or assessment tool was used</p> <p><i>OR</i></p> <p>CPT II Code: 1003F Level of activity assessed.</p> <p>*Standardized scale or assessment tools may include the New York Heart Association Functional Classification of Congestive Heart Failure (level of activity only); Kansas City Cardiomyopathy Questionnaire; Minnesota Living with Heart Failure™ Questionnaire; or Chronic Heart Failure Questionnaire (Guyatt).</p>	<p>All patient visits for patients aged ≥18 years with HF.</p> <p>Patient selection: ICD-9-CM Codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9</p> <p><i>AND</i></p> <p>CPT Codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404</p> <p><i>AND</i></p> <p>Patient age is ≥18 years.</p>	<p>None.</p>	<p>EHRS, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.</p>
<b>HEART FAILURE: ASSESSMENT OF CLINICAL SYMPTOMS OF VOLUME OVERLOAD (EXCESS)</b>	AMA PCPI/ACC/AHA <sup>2,3</sup>	<p>Patient visits with assessment of clinical symptoms of volume overload (excess) or documentation of standardized scale or completion of assessment tool.*</p> <p>Medical record must include: Assessment for the absence or presence of symptoms of volume overload – Dyspnea or orthopnea</p> <p><i>OR</i></p> <p>Documentation of standardized scale or completion of assessment tool</p> <p><i>OR</i></p> <p>CPT II Code: 1004F Clinical symptoms of volume overload (excess) assessed.</p>	<p>All patient visits for patients aged ≥18 years with HF.</p> <p>Patient selection: ICD-9-CM Codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9</p> <p><i>AND</i></p> <p>CPT Codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404</p> <p><i>AND</i></p> <p>Patient's age is ≥18 years.</p>	<p>None.</p>	<p>EHRS, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.</p>

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**HEART DISEASE (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>HEART FAILURE: ASSESSMENT OF CLINICAL SYMPTOMS OF VOLUME OVERLOAD (EXCESS)</b> <i>continued</i>		*Standardized scale or assessment tools may include the New York Heart Association Functional Classification of Congestive Heart Failure (level of activity only); Kansas City Cardiomyopathy Questionnaire; Minnesota Living with Heart Failure™ Questionnaire; or Chronic Heart Failure Questionnaire (Guyatt).			EHRS, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.
<b>HEART FAILURE: LEFT VENTRICULAR FUNCTION ASSESSMENT</b>	AMA PCPI/ACC/AHA <sup>2,3</sup>	Patients with quantitative or qualitative results of LVF assessment recorded. CPT Codes: 78414, 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 93543 And Medical record must include documentation of quantitative or qualitative results of LVF assessment Or CPT II Code: 3020F Left ventricular function (LVF) assessment (e.g., echocardiography, nuclear test, or ventriculography) documented in the medical record.	All patients with heart failure ≥18 years of age. Patient selection: ICD-9-CM Codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9	None. Patient's age is ≥18 years.	

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>HEART FAILURE: ANGIOTENSIN CONVERTING ENZYME INHIBITOR/ ANGIOTENSIN RECEPTOR BLOCKER THERAPY</b>	AMA PCPI/ ACC/AHA <sup>2,3</sup>  OR CPT II Code: 4009F Angiotensin Converting Enzyme (ACE) inhibitor or Angiotensin Receptor Blocker therapy prescribed.	<p>Patients who were prescribed ACE or ARB therapy (drug list available at <a href="http://www.ama-assn.org/ama/pub/category/4837.html">www.ama-assn.org/ama/pub/category/4837.html</a>)</p> <p>OR</p> <p>CPT II Code: 4009F Angiotensin Converting Enzyme (ACE) inhibitor or Angiotensin Receptor Blocker therapy prescribed.</p>	<p>All HF patients <math>\geq 18</math> years of age with LVEF <math>&lt;40\%</math> or with moderately or severely depressed left ventricular systolic function.</p> <p>Patient selection: ICD-9-CM Codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9</p> <p>AND</p> <p>CPT Procedure Codes for LVF assessment testing: 78414, 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 933543</p> <p>AND</p> <p>Additional individual medical record review must be completed to identify patients who had documentation of an ejection fraction <math>&lt;40\%</math> (use most recent value) or moderately or severely depressed left ventricular systolic function</p> <p>OR</p> <p>[CPT II Codes: 3021F Left ventricular ejection fraction (LVEF) <math>&lt;40\%</math> or documentation of moderately or severely depressed left ventricular systolic function</p> <p>AND</p> <p>Patient's age is <math>\geq 18</math> years.</p>	<p>Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy:</p> <ul style="list-style-type: none"> <li>■ Allergy or intolerance to ACE inhibitor or ARB</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ ACE inhibitor contraindications including angioedema, anuric renal failure, moderate or severe aortic stenosis or pregnancy ICD-9-CM Exclusion Codes: 440.1, V56.0, V56.8, 39.95, 54.98, 788.5, 586, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 584.5-584.9, 585.5-585.6, 395.0, 395.2, 396.0, 396.2, 396.8, 425.1, 747.22, V22.0-V23.9, 277.6 <p>OR</p> <ul style="list-style-type: none"> <li>■ Other medical reason documented by the practitioner for not prescribing ACE inhibitor or ARB therapy</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier: 4009F 1P. Patient reason (e.g., economic, social, religious)</li> </ul> <p>OR</p> <p>CPT II Code w/modifier: 4009F 2P. Documentation of system reason(s) for not prescribing ACE inhibitor or ARB therapy</p> <p>OR</p> <p>CPT II Code 4099F 3P.</p> </li></ul>	<p>EHRs, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.</p> <p>(more)</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HEART DISEASE (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>HEART FAILURE: PATIENT EDUCATION</b>	AMA PCP/ ACC/AHA <sup>2,3</sup>	<p>Patients provided with patient education during one or more visit(s).</p> <p>Patient education should include one or more of the following: weight monitoring; diet (sodium restriction); symptom management; physical activity; smoking cessation; medication instruction; minimizing or avoiding use of NSAIDs; referral for visiting nurse or specific educational or management programs; or prognosis/end-of-life issues.</p> <p>CPT II Code: 4003F Patient education, written/oral, appropriate for patients with heart failure performed.</p>	<p>All patient visits for patients aged ≥18 years with HF.</p> <p>Patient selection: ICD-9-CM Codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9</p> <p>AND</p> <p>CPT Codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404</p> <p>AND</p> <p>Patient age is ≥18 years.</p>	<p>None.</p>	<p>EHRS, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.</p>
<b>HEART FAILURE: BETA BLOCKER THERAPY</b>	AMA PCP/ ACC/AHA <sup>2,3</sup>	<p>Patients who were prescribed beta blocker therapy (drug list available at <a href="http://www.ama-assn.org/ama/pub/category/4837.html">www.ama-assn.org/ama/pub/category/4837.html</a>)</p> <p>OR</p> <p>CPT II Code: 4006F beta blocker therapy prescribed.</p>	<p>All HF patients ≥18 years of age with LVEF &lt;40% or with moderately or severely depressed left ventricular systolic function.</p> <p>Patient selection: ICD-9-CM Codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9</p> <p>AND</p> <p>CPT Procedure Codes for LVF assessment testing: 78414, 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 93354</p> <p>AND</p> <p>Additional individual medical record review must be completed to identify patients who had documentation of an ejection fraction &lt;40% (use most recent value) or moderately or severely depressed left ventricular systolic function</p>	<p>Documentation of medical reason(s) for not prescribing beta blocker therapy:</p> <ul style="list-style-type: none"> <li>■ Documentation of bradycardia &lt;50 bpm (without beta blocker therapy) on two consecutive readings; history of Class IV (congestive) heart failure, history of second- or third-degree atrioventricular (AV) block without permanent pacemaker.</li> </ul> <p>ICD-9-CM Exclusion Codes: 493.00-493.92, 458.0-458.1, 458.21, 458.29, 458.8-458.9, 426.0 without V45.01, 426.12 without V45.01, 426.13 without V45.01, 427.81, 427.89</p> <p>Or</p> <ul style="list-style-type: none"> <li>■ Other medical reason(s) documented by the practitioner for not prescribing beta blocker therapy</li> </ul> <p>(more)</p>	<p>EHRS, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.</p>

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**HEART DISEASE (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>HEART FAILURE: BETA BLOCKER THERAPY</b> <i>continued</i>			<p>OR</p> <p>[CPT II Codes: 3021F Left ventricular ejection fraction (LVEF) &lt;40% or documentation of moderately or severely depressed left ventricular systolic function;</p> <p>AND</p> <p>Patient's age is ≥18 years.</p>	<p>OR</p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier: 4006F 1P Documentation of patient reason(s) (e.g., economic, social, religious)</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier: 4006F 2P Documentation of system reason(s) for not prescribing beta blocker therapy</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ CPT II Code w/modifier 4006F 3P:</li> </ul>	<p>EHRs, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.</p>
<b>HEART FAILURE: WARFARIN THERAPY</b> <b>FOR PATIENTS WITH ATRIAL FIBRILLATION</b>	AMA PCPI/ ACC/AHA <sup>23</sup>	<p>Patients who were prescribed warfarin therapy (drug list available at <a href="http://www.ama-assn.org/ama/pub/category/4837.html">www.ama-assn.org/ama/pub/category/4837.html</a>)</p> <p>OR</p> <p>CPT II Code: 4012F Warfarin therapy prescribed.</p>	<p>All HF patients ≥18 years of age with paroxysmal or chronic atrial fibrillation.</p> <p>Patient selection: ICD-9-CM Codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9</p> <p>AND</p> <p>ICD-9-CM Code for atrial fibrillation: 427.31</p> <p>AND</p> <p>Patient's age is ≥18 years.</p>	<p>Documentation of medical reason(s) for not prescribing warfarin therapy:</p> <ul style="list-style-type: none"> <li>■ Allergy/intolerance 995.0 and E934.2, 995.1 and E934.2, 995.2 and E934.2</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ Risk of bleeding or bleeding disorder ICD-9-CM Exclusion Codes: 203.00-208.91, 280.0, 280.9, 285.1, 286.0-286.7, 286.9, 287.30-287.31, 287.32-287.33, 287.39, 287.4, 287.5, 430, 431, 432.0, 432.1, 432.9, 437.3, 459.0, 530.7, 531.00-531.01, 531.20-531.21, 531.40-531.41, 531.60-531.61, 532.0-532.01, 532.20-532.21, 532.40-532.41, 532.60-532.61, 533.00-533.01, 533.20-533.21, 533.40-533.41, 533.60-533.61, 534.00-534.01, 534.20-534.21, 534.40-534.41, 534.60-534.61, 569.3, 570, 571.2, 571.5, 578.0, 578.1, 578.9, 599.7, 786.3</li> </ul>	<p>EHRs, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.</p> <p>(more)</p>

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**HEART DISEASE (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>HEART FAILURE: WARFARIN THERAPY FOR PATIENTS WITH ATRIAL FIBRILLATION</b> <i>continued</i>			<p>■ Other medical reason(s) documented by the practitioner for not prescribing warfarin therapy</p> <p>OR</p> <p>■ CPT II Code w/modifier: 4012F 1P.</p> <p>Documentation of patient reason(s) (e.g., economic, social, religious)</p> <p>OR</p> <p>■ CPT II Code w/modifier: 4012F 2P.</p> <p>Documentation of system reason(s) for not prescribing warfarin therapy</p> <p>OR</p> <p>CPT II Code 4012F 3P.</p>	<p>Patient visits in which practitioner was unable to weigh patient.</p> <p>CPT II Code w/modifier: 2001F 1P.</p>	<p>EHRs, retrospective paper medical records,</p> <p>prospective flowsheet,</p> <p>administrative data using CPT II Codes.</p>
<b>HEART FAILURE: WEIGHT MEASUREMENT</b>	AMA PCPI/ ACC/AHA <sup>2,3</sup>	<p>Patient visits with weight measurement recorded</p> <p>OR</p> <p>CPT II Code: 2001F Weight recorded.</p>	<p>All visits for patients with HF ≥18 years of age</p> <p>Patient selection: ICD-9-CM Codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9</p> <p>AND</p> <p>CPT Codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404</p> <p>AND</p> <p>Patient's age is ≥18 years.</p>	(more)	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### HYPERTENSION

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
BLOOD PRESSURE MEASUREMENT	AMA PCP <sup>2,3</sup> ACC/AHA	Patient visits with BP measurement recorded <i>OR</i> CPT II Code: 2000F Blood pressure measured.	All visits for patients $\geq 18$ years of age with diagnosed hypertension.  Patient selection: ICD-9-CM Codes for hypertension: 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93 <i>AND</i> CPT office or other outpatient service codes: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404, <i>AND</i> Patient's age is $\geq 18$ years.	None.	Electronic health records, administrative data using CPT II Codes, retrospective paper medical records, prospective flowsheet.
PLAN OF CARE	AMA PCP <sup>2,3</sup> ACC/AHA	Patient visits with a documented plan of care for hypertension.  Plan of care should include one or more of the following: recheck BP at specified future date, initiate or alter antihypertensive pharmacological therapy, and/or initiate or alter non-pharmacological therapy. Non-pharmacological therapy may include weight reduction, decreased sodium and alcohol intake, and exercise <i>OR</i> CPT II Code 4050F: Hypertension plan of care documented as appropriate.	All visits for patients $\geq 18$ years of age with diagnosed hypertension during which either systolic BP $\geq 140$ mm Hg or diastolic BP $\geq 90$ mm Hg.  Patient selection: ICD-9-CM Codes for hypertension: 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93 <i>AND</i> CPT office or other outpatient service codes: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 <i>AND</i>	None.	Electronic health records, administrative data using CPT II Codes, retrospective paper medical records, prospective flowsheet.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**HYPERTENSION (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>PLAN OF CARE</b> <i>continued</i>			<p>Additional individual medical record review must be completed to identify patient visits with a systolic BP <math>\geq 140</math> mm Hg or a diastolic BP <math>\geq 90</math> mm Hg  <i>Or</i>            CPT II Codes (report one code for systolic):            3074F Most recent systolic blood pressure <math>&lt; 130</math> mm Hg <i>Or</i>            3075F Most recent systolic blood pressure 130 to 139 mm Hg <i>Or</i>            3077F Most recent systolic blood pressure <math>\geq 140</math> mm Hg  <i>And</i>            (report one code for diastolic)            3078F Most recent diastolic blood pressure <math>&lt; 80</math> mm Hg <i>Or</i>            3079F Most recent diastolic blood pressure 80 to 89 mm Hg <i>Or</i>            3080F Most recent diastolic blood pressure <math>\geq 90</math> mm Hg  <i>And</i>            Patient's age is <math>\geq 18</math> years.</p>	<p>None.</p>	<p>Electronic health records, retrospective flowsheet, medical record review.</p>
<b>CONTROLLING HIGH BLOOD PRESSURE</b>	CMS/NQCA <sup>2,4</sup>	<p>Patients with last BP measurement adequately controlled to systolic BP <math>&lt; 140</math> mm Hg <i>and</i> diastolic BP <math>&lt; 90</math> mm Hg during the measurement year.</p>	<p>All patients <math>\geq 18</math> years of age with a diagnosis of hypertension in the first six months of the measurement year or any time prior.            Patient selection: ICD-9-CM Codes for Hypertension: 401.</p> <p>A patient is considered to be hypertensive if there is at least one outpatient encounter (outpatient or other outpatient services) 99201-99205, 99211-99215, 99241, 99245, 99384-99387, 99394-99397 with a diagnosis of hypertension</p>	<p>(more)</p>	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**HYPERTENSION (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CONTROLLING HIGH BLOOD PRESSURE</b> <i>continued</i>			<p>(applicable ICD-9 Codes) during the first six months of the measurement year. To confirm the diagnosis of hypertension, notation of the following must be found in the medical record on or before June 30 of the measurement year:</p> <ul style="list-style-type: none"> <li>■ HTN</li> <li>■ High blood pressure (HBP)</li> <li>■ Elevated BP</li> <li>■ Borderline HTN</li> <li>■ Intermittent HTN</li> <li>■ History of HTN.</li> </ul> <p>The notation of hypertension may appear anytime on or before June 30 of the measurement year, including prior to the measurement year. It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded on any of the following documents:</p> <ul style="list-style-type: none"> <li>■ A problem list,</li> <li>■ A problem list,</li> <li>■ Office note,</li> <li>■ Subjective, objective, assessment plan (SOAP) note,</li> <li>■ Encounter form,</li> <li>■ Telephone call record,</li> <li>■ Diagnostic report, and/or</li> <li>■ Hospital discharge summary.</li> </ul> <p>Statements such as "rule out hypertension," "possible hypertension," "white-coat hypertension," "questionable hypertension," and "consistent with hypertension" are not sufficient to confirm the diagnosis of hypertension if such statements are the only notations of hypertension in the medical record.</p>		(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MEDICATION MANAGEMENT

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>DOCUMENTATION OF MEDICATION LIST IN THE OUTPATIENT RECORD</b>	CMS-SCRIPT <sup>5</sup>	Patients with a medication list <sup>6</sup> in their medical record.	All patients who were continuously enrolled during the measurement year.	NA	Chart abstraction via paper-based abstraction tool designed for SCRIPT project.
<b>DOCUMENTATION OF ALLERGIES AND ADVERSE REACTIONS IN THE OUTPATIENT RECORD</b>	CMS-SCRIPT <sup>5</sup>	Patients with allergy and adverse reaction status <sup>7</sup> present in medical record.	All patients who were continuously enrolled during the measurement year.	NA	Chart abstraction via paper-based abstraction tool designed for SCRIPT project.
<b>THERAPEUTIC MONITORING: ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS</b>	NCQA <sup>2,4</sup>	Electronic Collection:  Numerator a: The number of patients with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.  Note: The two tests do not need to occur on the same service date, only within the measurement year.  Codes to identify physiologic monitoring tests (for patients on ACE inhibitors or ARBs, digoxin or diuretics and any combination products):  Serum Potassium (K+): CPT Codes: 84132, 80050, 80051, 80053, 80048, 80069; ICD-9-CM Codes: 2824-1, 2823-3, 6298-4, 12812-4, 12813-2, 22760-3, 24320-4, 24321-2, 24322-0, 24323-8, 24326-1, 24362-6, 29349-8, 32713-0, 34548-8, 34554-6 AND	Electronic Collection:  Denominator a: The number of patients ages 18 years and older who received at least a 180-days supply of ACE inhibitors or ARBs, including any combination products during the measurement year.  A list of included drugs can be accessed at: <a href="http://www.ncqa.org/Programs/HEDIS/2006/Volume2/NDCLicense.htm">www.ncqa.org/Programs/HEDIS/2006/Volume2/NDCLicense.htm</a> .	Exclude patients from each rate denominator with a hospitalization in the measurement year. These patients may have received a monitoring event during the hospitalization which may not be captured. Hospitalizations can be identified using either codes for inpatient discharges or non-acute care or through the medical record.	Electronic data (i.e., claims or encounter data for visits, laboratory tests and pharmacy) or medical record review.
<b>a. Annual monitoring for patients on angiotensin converting enzyme inhibitors/ angiotensin receptor blockers</b>				Codes to identify total inpatient discharges: ICD-9-CM Codes: (all principal diagnosis codes except: 290-316, 960-979 with a secondary diagnosis of chemical dependency, V30-V39) ICD-10-CM Codes: (Type of Bill Codes: 11X, 12X, 41X, 42X, 84X) OR DRGs: (1-423, 439-455, 461, 463-471, 473, 475-520, 524-540, 541-559) OR ICD-9-CM (more)	

<sup>5</sup> The SCRIPT measures were developed by the Coalition for Quality in Medication Use funded by the Centers for Medicare and Medicaid Services and are in the public domain. Since the project has concluded and the coalition is no longer available to maintain the measures, NCQA has indicated that it will maintain them.

<sup>6</sup> A separate, additional document can satisfy the numerator, as can a list of medications simply noted in a patient's progress note.

<sup>7</sup> A separate, additional document can satisfy the numerator, as can a note in a patient's progress note.

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MEDICATION MANAGEMENT (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>THERAPEUTIC MONITORING: ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS</b>		<p>Serum Creatinine (SC): CPT Codes: 82565, 80050, 80053, 80048, 80069, 82575; LOINC Codes: 2160-0, 2163-4, 2164-2, 11041-1, 11042-9, 12195-4, 13441-1, 13442-9, 13443-7, 13446-0, 13447-8, 13449-4, 13450-2, 14682-9, 16188-5, 16189-3, 22323-4, 24321-2, 24322-0, 24323-8, 24320-4, 24362-6, 26752-6, 33558-8, 34555-3, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4 OR Blood Urea Nitrogen (BUN): CPT Codes: 84520, 84525, 80050, 80053, 80048, 80069; LOINC Codes: 3094-0, 6299-2, 11064-3, 11065-0, 12964-3, 12965-0, 12966-8, 14937-7, 24320-4, 24321-2, 24322-0, 24323-8, 24362-6.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator a:</b> Documentation in the medical record must include, at a minimum, at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</p> <p><b>Note:</b> The two tests do not need to occur on the same service date, only within the measurement year.</p>	<p>Denominator a: The number of patients ages 18 years and older who received a prescription for at least a 180-days supply of ACE-inhibitors or ARBs, including any combination products during the measurement year (refer to drug lists detailed in the denominator statement for the electronic version).</p> <p>For medical record extraction, a sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective, or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p>	<p>Codes: (all principal diagnosis codes with an inpatient facility code except: 290-316, 960-979 with a secondary diagnosis of chemical dependency/V30-V39). Codes to identify non-acute care: Hospice - UB-92 Type of Bill Codes (81X, 82X), UB-92 Revenue Codes (115, 125, 135, 145, 155, 650, 656, 658, 659)</p> <p>SNF - UB-92 Type of Bill Codes (0524, 0525, 21X, 22X), UB-92 Revenue Codes (19X)</p> <p>Hospital transitional care, swing bed or rehabilitation - UB-92 Type of Bill Codes (18X)</p> <p>Rehabilitation - UB-92 Revenue Codes (118, 128, 138, 148, 158), DRG (462)</p> <p>Respite - UB-92 Revenue Codes (655)</p> <p>OR</p> <p>Other non-acute care facilities that do not use the UB-92 for billing (ICF, SNF, etc.).</p>	(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MEDICATION MANAGEMENT (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>b. Annual monitoring for patients on digoxin</b>	NCQA	<p><b>Electronic Collection:</b></p> <p><b>Numerator b:</b> The number of patients with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</p> <p><b>Note:</b> The two tests do not need to occur on the same service date, only within the measurement year.</p> <p>Codes to identify physiologic monitoring tests (for patients on ACE inhibitors or ARBs, digoxin, or diuretics and any combination products):</p> <p><b>Serum Potassium (K+):</b> CPT Codes: 84132, 80050, 80051, 80053, 80048, 80069; I0INC Codes: 2824-1, 2823-3, 6298-4, 12812-4, 12813-2, 22760-3, 24320-4, 24321-2, 24322-0, 24323-8, 24326-1, 24362-6, 29349-8, 32713-0, 34548-8, 34554-6 AND</p> <p><b>Serum Creatinine (Scr):</b> CPT Codes: 82565, 80050, 80053, 80048, 80069, 82575; I0INC Codes: 2160-0, 2163-4, 2164-2, 11041-1, 11042-9, 12195-4, 13441-1, 13442-9, 13443-7, 13446-0, 13447-8, 13449-4, 13450-2, 14682-9, 16188-5, 16189-3, 21232-4, 24321-2, 24322-0, 24323-8, 24320-4, 24362-6, 26752-6, 33558-8, 34555-3, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4 OR</p> <p><b>Blood Urea Nitrogen (BUN):</b> CPT Codes: 84520, 84525, 80050, 80053, 80048, 80069; LOINC Codes: 3094-0, 6299-2, 11064-3, 11065-0, 12964-3, 12965-0, 12966-8, 14937-7, 24320-4, 24321-2, 24322-0, 24323-8, 24362-6.</p>	<p>Exclude patients from each rate denominator with a hospitalization in the measurement year. These patients may have received a monitoring event during the hospitalization which may not be captured. Hospitalizations can be identified using either codes for inpatient discharges or non-acute care or through medical records.</p> <p>Codes to identify total inpatient discharges: ICD-9-CM Codes: (all Principal Diagnosis Codes except: 290-316, 960-979 with a secondary diagnosis of chemical dependency, V30-V39) <i>WITH</i> UB-92 Codes: (type of bill codes: 11X, 12X, 41X, 42X, 84X) <i>OR</i> DRGs: (1-423, 439-455, 461, 463-471, 473, 475-520, 524-540, 541-559) <i>OR</i> ICD-9-CM Codes: (all principal diagnosis codes with an inpatient facility code except: 290-316, 960-979 with a secondary diagnosis of chemical dependency, V30-V39).</p> <p>Codes to identify non-acute care: Hospice - UB-92 Type of Bill Codes (81X, 82X), UB-92 Revenue Codes (115, 125, 135, 145, 155, 650, 656, 658, 659)</p> <p>SNF-UB-92 Type of Bill Codes (0524, 0525, 21X, 22X), UB-92 Revenue Codes (19X)</p> <p>Hospital transitional care, swing bed or rehabilitation - UB-92 Type of Bill Codes (18X)</p> <p>Rehabilitation - UB-92 Revenue Codes (118, 128, 138, 148, 158), DRG (462) <i>(more)</i></p>	<p>Electronic data (i.e., claims or encounter data for visits, laboratory tests and pharmacy) or medical record review.</p>	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MEDICATION MANAGEMENT (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>b. Annual monitoring for patients on digoxin</b> <i>continued</i>		<p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator b:</b> Documentation in the medical record must include, at minimum, a note indicating the patient received at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</p>	<p>Respite - UB-92 Revenue Code (655) OR Other non-acute care facilities that do not use the UB-92 for billing (ICF, SNF, etc.).</p>		
<b>c. Annual monitoring for patients on diuretics</b>	NQCA	<p><b>Electronic Collection:</b></p> <p><b>Numerator c:</b> The number of patients with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</p> <p><b>Note:</b> The two tests do not need to occur on the same service date, only within the measurement year.</p> <p>Codes to identify physiologic monitoring tests (for patients on ACE inhibitors or ARB, Digoxin, or Diuretics and Any Combination Products):</p> <p><b>Serum Potassium (K+): CPT Codes: 84132, 80050, 80051, 80053, 80048, 80069; ICD Codes: 2824-1, 2823-3, 6298-4, 12813-2, 22760-3, 24320-4, 24321-2, 24322-0, 24323-8, 24326-1, 24362-6, 29349-8, 32713-0, 34548-8, 34554-6 AND</b></p>	<p>Exclude patients from each rate denominator with a hospitalization in the measurement year. These patients may have received a monitoring event during the hospitalization which may not be captured. Hospitalizations can be identified using either codes for inpatient discharges or non-acute care or medical records.</p> <p>Codes to identify total inpatient discharges: ICD-9-CM Codes: (all principal diagnosis codes except: 290-316, 960-979 with a secondary diagnosis of chemical dependency, V30-V39) <i>WITH</i> UB-92 Codes: (type of bill codes: 11X, 12X, 41X, 42X, 84X) OR DRGs: (1-423, 439-455, 461, 463-471, 473, 475-520, 524-540, 541-559) OR ICD-9-CM Codes: (all principal diagnosis codes with an inpatient facility code except: 290-316,</p> <p>(more)</p>		

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MEDICATION MANAGEMENT (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>c. Annual monitoring for patients on diuretics</b> <i>continued</i>		Serum Creatinine (SC): CPT Codes: 82565, 80050, 80053, 80048, 80069, 82575; ICD Codes: 2160-0, 2163-4, 2164-2, 11041-1, 11042-9, 12195-4, 13441-1, 13442-9, 13443-7, 13446-0, 13447-8, 13449-4, 13450-2, 14682-9, 16188-5, 16189-3, 21232-4, 24321-2, 24322-0, 24323-8, 24320-4, 24362-6, 26752-6, 33558-8, 34555-3, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4 OR Blood Urea Nitrogen (BUN): CPT Codes: 84520, 84525, 80050, 80053, 80048, 80069; ICD Codes: 3094-0, 6299-2, 11064-3, 11065-0, 12964-3, 12965-0, 12966-8, 14937-7, 24320-4.	<p>settings office visit claims or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective, or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p> <p><b>Denominator c:</b> The number of patients ages 18 years and older who received a prescription for at least a 180-days supply of a diuretic, including any combination products, during the measurement year.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator c:</b> Documentation in the medical record must include, at minimum, a note indicating the patient received at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</p> <p><i>Note:</i> The two tests do not need to occur on the same service date, only within the measurement year.</p>	<p>960-979 with a secondary diagnosis of chemical dependency, V30-V39.</p> <p>Codes to identify non-acute care: Hospice - UB-92 Type of Bill Codes (81X, 82X), UB-92 Revenue Codes (115, 125, 135, 145, 155, 650, 656, 658, 659)</p> <p>SNF - UB-92 Type of Bill Codes (0524, 0525, 21X, 22X), UB-92 Revenue Codes (19X)</p> <p>Hospita transitional care, swing bed or rehabilitation - UB-92 Type of Bill Codes (18X)</p> <p>Rehabilitation - UB-92 Revenue Codes (118, 128, 138, 148, 158), DRG (462)</p> <p>Respite - UB-92 Revenue Codes (655)</p> <p>OR</p> <p>Other non-acute care facilities that do not use the UB-92 for billing (ICF, SNF, etc.).</p>	(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MEDICATION MANAGEMENT (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
d. Annual monitoring for patients on anticonvulsants	NCQA	<p><b>Electronic Collection:</b></p> <p>Numerator d: The number of patients with at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year. If a patient received only one type of anticonvulsant, the drug serum concentration level test must be for the specific drug taken as a persistent medication. If a patient persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., a patient on both phenytoin and valproic acid with at least a 180-days supply for each drug in the measurement year must separately show evidence of receiving drug serum concentration tests for each drug to be considered numerator-compliant for each drug).</p> <p>Codes to identify drug serum concentration monitoring tests: Drug serum concentration for Phenobarbital: CPT Code: 80184, LOINC Codes: 3048-7, 3951-1, 10547-8, 14874-2, 34365-7; Drug serum concentration for phenytoin: CPT Codes: 80185, 80186, LOINC Codes: 3568-5, 3969-3, 14877-5, 32109-1, 34540-5; Drug serum concentration for valproic acid: CPT Code: 80164; LOINC Codes: 4086-5, 4087-3, 4088-1, 14946-8, 18489-5, 21590-5, 32119-0, 322283-4; Drug serum concentration for carbamazepine: CPT Codes: 80156, 80157; LOINC Codes: 3432-2, 3433-0, 9415-1, 14056-6, 14639-9, 18270-9, 29147-6, 29148-4, 32058-0, 32852-6, 34545-4.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology (more)</p>	<p><b>Electronic Collection:</b></p> <p>Denominator d: The number of patients in the denominator who received at least a 180-days supply for any anticonvulsant for phenytoin, phenobarbital, valproic acid, or carbamazepine during the measurement year. Each patient-drug combination is considered a unique event.</p> <p><b>Note:</b> To count toward the denominator, patients must be on one of the four anticonvulsant medications listed during the measurement year for at least a 180-days supply. Patients who are on multiple anticonvulsant drugs count toward the denominator multiple times if they meet the persistent medications criteria for each drug taken during the measurement year (i.e., a patient who received at least 180 days of phenytoin and 180 days of valproic acid will be counted twice in the denominator for rate 4, once for each drug).</p> <p>A list of included drugs can be accessed at: <a href="http://www.ncqa.org/Programs/HEDIS/2006/Volume2/NDCLicense.htm">www.ncqa.org/Programs/HEDIS/2006/Volume2/NDCLicense.htm</a>.</p> <p><b>Medical Record Collection:</b> For medical record extraction, a sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective, or prospective from a specific date) can then be chosen for the</p>	<p>Exclude patients from each rate denominator with a hospitalization in the measurement year. These patients may have received a monitoring event during the hospitalization which may not be captured. Hospitalizations can be identified using either codes for inpatient discharges or non-acute care.</p> <p>Codes to identify total inpatient discharges: ICD-9-CM Codes: (all principal diagnosis codes except: 290-316, 960-979 with a secondary diagnosis of chemical dependency, V30-V39) WITH UB-92 Codes: (type of bill codes: 11X, 12X, 42X, 84X) OR DRGs: (1-423, 439-455, 461, 463-471, 473, 475-520, 524-540, 541-559) OR ICD-9-CM Codes: (all principal diagnosis codes with an inpatient facility code except: 290-316, 960-979 with a secondary diagnosis of chemical dependency, V30-V39).</p> <p>Codes to identify non-acute care: Hospice - UB-92 Type of Bill Codes (81X, 82X), UB-92 Revenue Codes (115, 125, 135, 145, 155, 650, 656, 658, 659)</p> <p>SNF - UB-92 Type of Bill Codes (0524, 0525, 21X, 22X), UB-92 Revenue Codes (19X)</p> <p>Hospital transitional care, swing bed or rehabilitation - UB-92 Type of Bill Codes (18X)</p> <p>Rehabilitation - UB-92 Revenue Codes (118, 128, 138, 148, 158), DRG (462)</p>	<p>Electronic data (i.e., claims or encounter data for visits, laboratory tests and pharmacy) or medical record review.</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MEDICATION MANAGEMENT (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>d. Annual monitoring for patients on anticonvulsants</b> <i>continued</i>		<p>described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator d:</b> The number of patients with documentation of at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year. If a patient received only one type of anticonvulant, the drug serum concentration level test must be for the specific drug taken as a persistent medication. If a patient persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., a patient on both phenytoin and valproic acid with at least a 180-days supply for each drug in the measurement year must separately show evidence of receiving drug serum concentration tests for each drug to be considered numerator-compliant for each drug).</p> <p>Drug serum concentration monitoring tests: drug serum concentration for phenobarbital; drug serum concentration for phenytoin; drug serum concentration for valproic acid; drug serum concentration for carbamazepine.</p>	<p>denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p> <p><b>Denominator d:</b> The number of patients in the denominator who received a prescription for at least a 180-days supply for any anticonvulant for phenytoin, phenobarbital, valproic acid, or carbamazepine during the measurement year. Each patient-drug combination is considered a unique event.</p> <p><i>Note:</i> To count toward the denominator, patients must have a prescription for one of the four anticonvulsant medications listed during the measurement year for at least a 180-days supply.</p>	<p>Respite - UB-92 Revenue Codes (655) OR Other non-acute care facilities that do not use the UB-92 for billing (ICF, SNF, etc.).</p>	<p>See individual measure specifications.</p>
<b>e. Annual monitoring: combined rate<sup>s</sup></b>	NQCA	Sum of the four numerators (a-d).	Sum of the four denominators (a-d).	<p>See individual measure specifications.</p> <p>(more)</p>	<p>See individual measure specifications.</p>

<sup>s</sup> The measure “annual monitoring for patients on statins” has recently been retired from the NCQA measure set due to the inconsistency of the clinical guidelines around annual monitoring for statin use.

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MEDICATION MANAGEMENT (continued)

Measure	IP Owner	Numerator	Denominator	Exclusions	Data Source
<b>DRUGS TO BE AVOIDED IN THE ELDERLY</b>	NCQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> Numerator a: At least one prescription for any drug to be avoided in the elderly in the measurement year. A list of included drugs can be accessed at: <a href="http://www.ncqa.org/Programs/HEDIS/2006/Volume2/NDClicense.htm">www.ncqa.org/Programs/HEDIS/2006/Volume2/NDClicense.htm</a>.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator a:</b> Documentation in the medical record must include, at a minimum, a prescription for at least one drug to be avoided in the elderly in the measurement year.</p> <p><b>Numerator b:</b> At least two different drugs to be avoided in the elderly in the measurement year. A list of included drugs can be accessed at: <a href="http://www.ncqa.org/Programs/HEDIS/2006/Volume2/NDClicense.htm">www.ncqa.org/Programs/HEDIS/2006/Volume2/NDClicense.htm</a>.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator b:</b> Documentation in the medical record must include at a minimum, prescriptions for at least two different drugs to be avoided in the elderly in the measurement year.</p>	<p>Electronic collection: Denominator a: All patients ages 65 years and older as of December 31 of the measurement year.</p> <p><b>Medical Record Collection:</b> For medical record extraction, a sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective, or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p> <p><b>Denominator:</b> Patients ages 65 years and older as of December 31 of the measurement year.</p>	NA	Electronic data (i.e., claims or encounter data for visits, laboratory tests and pharmacy) or medical record review.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>MAJOR DEPRESSIVE DISORDER; DIAGNOSTIC EVALUATION</b>	AMA PCP <sup>2,3</sup>	<p>Patients with documented evidence that they met the DSM–IV™ criteria [at least 5 elements (including 1) depressed mood or 2) loss of interest or pleasure) with symptom duration of two weeks or longer] during the visit in which the new diagnosis or recurrent episode was identified.</p> <ul style="list-style-type: none"> <li>■ CPT II Code: 1040F DSM–IV™ criteria for MDD documented.</li> <li>■ The criteria for a MDD episode includes five (or more) of nine specific symptoms which have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure:</li> </ul> <ul style="list-style-type: none"> <li>● Depressed mood;</li> <li>● Marked diminished interest/pleasure;</li> <li>● Significant weight loss or gain;</li> <li>● Insomnia or hypersomnia;</li> <li>● Psychomotor agitation/retardation;</li> <li>● Fatigue or loss of energy;</li> <li>● Feelings of worthlessness;</li> <li>● Diminished ability to concentrate; and</li> <li>● Recurrent suicidal ideation.</li> </ul>	<p>All patients aged ≥18 years with a new diagnosis or recurrent episode of MDD during the reporting year</p> <p>Patient selection: ICD-9-CM Codes for MDD: 296.20-296.24, 296.30-296.34 AND</p> <p>Documentation of new episode of MDD CPT II Code: 309.3; Documentation of a new diagnosis or recurrent episode of MDD</p> <p>AND</p> <p>CPT Codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 OR</p> <p>CPT Codes for psychiatric visits: 90801, 90802 AND</p> <p>Patient's age is ≥18 years.</p>	<p>None.</p>	<p>EHRS, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.</p>

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>MAJOR DEPRESSIVE DISORDER: SUICIDE RISK ASSESSMENT<sup>9</sup></b>	AMA PCP <sup>2,3</sup>	Patients who had a suicide risk assessment completed at each visit; CPT II Code: 3085F Suicide risk assessed.	All patients aged ≥18 years with a new diagnosis or recurrent episode of MDD during the reporting year. Patient selection: ICD-9-CM Codes for MDD: 296.20-296.24, 296.30-296.34 <i>AND</i> Documentation of new episode of MDD CPT II Code: 3093F Documentation of a new diagnosis or recurrent episode of MDD <i>AND</i> CPT Codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404, 90862, 90805, 90807, 90809, 90811, 90813, 90815, 90804, 90806, 90808, 90810, 90812, 90814, 90845, 90847, 90849, 90853, 90857 <i>AND</i> Patient's age is ≥18 years.	Documentation that patient is in remission (no longer meeting DSM-IV™ criteria) <i>OR</i> CPT II Code 3092F-Major Depression Disorder, in Remission.	EHRs, retrospective paper medical records, prospective flowsheet, administrative data using CPT II Codes.
<b>NEW EPISODE OF DEPRESSION</b>	NCOA <sup>2,4</sup>	<b>Electronic Collection:</b> <b>Numerator a:</b> Optimal contacts for medication management: Three or more outpatient follow-up visits or intermediate treatment with a practitioner (at least one of which is prescribing practitioner) within 84 days (i.e., within the 12-week acute treatment phase) after a new diagnosis of major depression. All three follow-up visits are expected to be for mental health. Two of the three follow-up visits must be face-to-face. Case management services should not be counted toward this measure. <i>OR</i>	<b>Denominator for rates a, b, c (electronic):</b> Patients 18 years and older as of April 30th of the measurement year diagnosed with a New Episode of Major Depressive Disorder during the Intake Period and treated with antidepressant medication. Step 1: Identify all patients with a diagnosis of depression who during the 12-month intake period had: ■ At least one principal diagnosis of major depression in any setting <i>OR</i>	Risk adjustment is not applied; although the measure is collected for the specific age cohort 18 years and older. See numerators and denominators above for inclusions and exclusions. Definitions are as follows: Intake Period: The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year. Used to capture New Episodes of treatment Index Episode Start Date: The earliest episode during the Intake Period with a qualifying diagnosis of major depression.	The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for mental health visits (inpatient (more)

<sup>9</sup> During harmonization discussion, the measure developer noted that the intent of this measure is to conform to the American Psychiatric Association's guidelines for suicide risk assessment. Future iterations of the measure will include a reference to the American Psychiatric Association guidelines.

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>NEW EPISODE OF DEPRESSION</b>		<p>Identify all patients in the denominator population who had:</p> <ul style="list-style-type: none"> <li>■ Three face-to-face follow-up office visits or intermediate treatment with a practitioner within 84 days (12 weeks) after the Index Episode Start Date,</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ Two face-to-face visits and one telephone visit with a mental health or non-mental health practitioner within 84 days (12 weeks) after the Index Episode Start Date.</li> </ul> <p>Do not count the Index Episode Start Date visit in cases where the patient had two visits with a secondary diagnosis of depression. Include the second visit with a secondary diagnosis of depression toward the optimal contacts rate. Emergency room visits do not count toward the numerator. Visits with mental health practitioners: To identify visits with mental health practitioners, use any of the codes listed below.</p> <p>Or</p> <p>Visits with non-mental health practitioners: To identify visits with non-mental health practitioners, use psychiatric visit codes listed below</p> <p>Or</p> <p>evaluation and management codes listed below in conjunction with a Mental Health Diagnosis Code or telephone visit codes in listed below in conjunction with a Mental Health Diagnosis Code.</p> <p>Codes to identify psychiatric visits: CPT Codes: 90801, 90802, 90804-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876; HCPCS: G0155, G0176,</p>	<ul style="list-style-type: none"> <li>■ At least two secondary diagnoses of major depression on different dates of service in any outpatient setting</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ At least one secondary diagnosis of major depression associated with any inpatient discharge.</li> </ul> <p>Codes to identify major depression: ICD-9 Codes: 296.2, 296.3, 298.0, 300.4, 309.1, 311; DRG Codes: 426*</p> <p>Prior depressive episodes: ICD-9 Codes: 296.2-296.9, 298.0, 300.4, 309.0, 309.1, 309.28, 311; DRG Codes: 426* (* exclude patients with this code if the Principal Diagnosis is ICD-9-CM Code 301.12).</p> <p>Step 2: Determine the Index Episode Start Date and test for negative diagnosis history. For each patient identified in step 1, determine the Index Episode Start Date by finding the date of the patient's earliest encounter during the Intake Period with a qualifying major depression diagnosis. Identify patients who were diagnosed with a New Episode of depression. Patients with a New Episode of depression are those who have a negative diagnosis history. The range of ICD-9-CM Diagnosis Codes for prior depressive episodes listed is more comprehensive to exclude patients diagnosed with any type of depression. Patients with any diagnosis of depression within the previous 120 days (4 months) of the Index Episode Start Date should be dropped from this denominator.</p> <p>Step 3: Identify patients receiving antidepressant medication therapy. Among patients identified in step 2, find those who filled a prescription for an</p>	<p>Index Prescription Date: The earliest prescription for antidepressants filled within a 44-day period, defined as 30 days prior to through 14 days on or after the Index Episode Start Date.</p> <p>Negative diagnosis history: A period of 120 days (4 months) on or before the Index Episode Start Date, during which time the patient had no claims/encounters containing either a principal or secondary diagnosis of depression.</p> <p>Negative medication history: A period of 90 days (3 months) prior to the Index Prescription Date, during which time the patient had no new or refill prescriptions for a listed antidepressant drug.</p> <p>New Episode: To qualify as a new episode, two criteria must be met:</p> <ul style="list-style-type: none"> <li>■ A 120-day (4-month) negative diagnosis history on or before the Index Episode Start Date.</li> <li>■ A 90-day (3-month) negative medication history on or before the Index Prescription Date.</li> </ul> <p><i>Prescribing Practitioner:</i> A practitioner with prescribing privileges.</p> <p><i>Treatment Days:</i> The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval.</p>	<p>and ambulatory), procedures, and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.</p> <p>As noted in the measure description, those practices that have electronic health records system can use either electronic or medical record approach but</p> <p>(more)</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>NEW EPISODE OF DEPRESSION</b>		<p>00177, H0002, H0004, H0031, H0034, H0036, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2020, M0064, S9484, S9485; UB-92 Codes: 0513, 0900, 0901, 0905-0907, 0909-0916, 0961.</p> <p>Evaluation and management codes: CPT codes: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401, 99404; AND one of the following ICD9-CM Codes: 290, 293-302, 306-316</p> <p>Telephone visits: CPT Codes: 99371-99373; and one of the following ICD9-CM Codes: 290, 293-302, 306-316.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator a:</b> Optimal contacts for medication management (medical record)</p> <p>Three or more outpatient follow-up visits or intermediate treatment with a practitioner (at least one of which is a prescribing practitioner) within 84 days (i.e., within the 12-week acute treatment phase) after a new diagnosis of major depression. All three follow-up visits are expected to be for mental health. Two of the three follow-up visits must be face-to-face. Case management services should not be counted toward this measure.</p>	<p>antidepressant medication within 30 days before the Index Episode Start Date or 14 days on or after the Index Episode Start Date.</p> <p>Step 4: Identify the Index Prescription Date: Identify the earliest prescription up to 30 days before the Index Episode Start Date to 14 days on or after the Index Episode Start Date. Prescriptions may be up to 30 days before the Index Episode Start Date to account for patients having a recurrent episode who may be started on medication based on a phone encounter while awaiting a scheduled office visit. Similarly, prescriptions may be 14 days on or after the Index Episode Start Date to account for either clinical discretion in recommending a 2-week trial of self-help techniques prior to starting on medication or for patient delay in filling the initial prescription.</p> <p>Step 5: From the resulting patients from step 4, confirm the New Episode by testing for a negative medication history. Patients who have antidepressant prescriptions filled during the negative medication history period do not represent new treatment episodes and must be excluded.</p> <p>Step 6: Exclude patients who had an acute mental health or substance abuse inpatient stay during the 245 days after the Index Episode Start Date treatment period.</p> <p>Codes to identify mental health inpatient services: DRG Codes: 424-432 except discharges with (D-9 principal diagnosis of 317-319 ICD-9 CM Codes: 290, 293-302, 306-316 Codes to identify chemical dependency inpatient services: DRG Codes: 433, 521-523 ICD-9 CM Codes: 291-292, 303-305,</p>	<p>include all eligible patients, rather than a sample, in both the denominator and numerator.</p> <p>(more)</p>	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>NEW EPISODE OF DEPRESSION</b>		<p>Identify all patients in the denominator population who had:</p> <ul style="list-style-type: none"> <li>■ Three face-to-face follow-up office visits or intermediate treatment with a practitioner within 84 days (12 weeks) after the Index Episode Start Date,</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ Two face-to-face visits and one telephone visit with either a practitioner within 84 days (12 weeks) after the Index Episode Start Date.</li> </ul> <p>Do not count the Index Episode Start Date visit in cases where the patient had two visits with a secondary diagnosis of depression. Include the second visit with a secondary diagnosis of depression toward the optimal contacts rate. Emergency room visits (in person or over the telephone) with non-mental health practitioners should be for a psychiatric visit or for a mental health diagnosis.</p>	<p>960-979 with a secondary diagnosis of chemical dependency.</p> <p><b>Denominator for Numerators a, b, c (medical record):</b> A systematic sample of patients 18 years and older as of April 30 of the measurement year diagnosed with a New Episode of Major Depressive Disorder during the Intake Period and who were prescribed antidepressant medication.</p> <p>Step 1: Identify all patients with a diagnosis of depression who, during the 12-month Intake Period had:</p> <ul style="list-style-type: none"> <li>■ At least one principal diagnosis of major depression in any setting</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ At least two secondary diagnoses of major depression on different dates of service in any outpatient setting</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ At least one secondary diagnosis of major depression associated with any inpatient discharge.</li> </ul> <p><b>Step 2: Determine the Index Episode Start Date and test for negative diagnosis history.</b> For each patient identified in step 1, determine the Index Episode Start Date by finding the date of the patient's earliest encounter during the Intake Period with a qualifying major depression diagnosis.</p> <p>Identify patients who were diagnosed with a New Episode of depression. Patients with a New Episode of depression are those who have a negative diagnosis history. Patients with any diagnosis of</p>	(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>NEW EPISODE OF DEPRESSION</b>  a. Optimal Practitioner Contacts for Medication Management <i>continued</i>			<p>depression within the previous 120 days (4 months) of the Index Episode Start Date should be dropped from this denominator.</p> <p>Step 3: Identify patients prescribed antidepressant medication therapy. Among patients identified in step 2, find those who have a prescription for an antidepressant medication within 30 days before the Index Episode Start Date or 14 days on or after the Index Episode Start Date.</p> <p>Step 4: Identify the Index Prescription Date. Identify the earliest written prescription up to 30 days before the Index Episode Start Date to 14 days on or after the Index Episode Start Date. Prescriptions may be up to 30 days before the Index Episode Start Date to account for patients having a recurrent episode who may be started on medication based on a phone encounter while awaiting a scheduled office visit. Similarly, written prescriptions may be 14 days on or after the Index Episode Start Date to account for either clinical discretion in recommending a 2-week trial of self-help techniques prior to starting on medication.</p> <p>Step 5: From the resulting patients from step 4, confirm the New Episode by testing for a negative medication history. Patients who have antidepressant prescriptions written during the negative medication history period do not represent new treatment episodes and must be excluded.</p> <p>Step 6: Exclude patients who had an acute mental health or substance abuse inpatient stay during the 245 days after the Index Episode Start Date</p>	(more)	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>b. Effective Acute Phase Treatment</b>	NCQA <sup>2,4</sup>	<p><b>Numerator b:</b> Effective acute phase treatment (electronic): An 84-day (12-week) acute treatment of antidepressant medication.</p> <p>Identify all patients in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 84 days. The continuous treatment definition allows gaps in medication treatment up to a total of 30 days during the 84-day period. Allowable medication changes or gaps include:</p> <ul style="list-style-type: none"> <li>■ “Washout” period gaps to change medication</li> <li>■ “Treatment” gaps to refill the same medication.</li> </ul> <p>Regardless of the number of gaps, the total gap days may be no more than 30 days. Any combination of gaps may be counted (e.g., two washout gaps, each 15 days, or two washout gaps of 10 days each and one treatment gap of 10 days). The total gap days may not exceed 30 days. To determine continuity of treatment during the 84-day period, sum the number of gap days to the number of treatment days for a maximum of 114 days (i.e., 84 treatment days + 30 gap days = 114 days).</p> <p>For all prescriptions filled within 114 days of the Index Prescription Date, count treatment days from the Index Prescription Date and continue to count until a total of 84 treatment days has been established. Patients whose gap days exceed 30 or who do not have 84 treatment days within 114 days after the Index Prescription Date are not counted in the numerator.</p>	<p><b>Denominator for rates a, b, c (electronic):</b> Patients 18 years and older as of April 30th of the measurement year diagnosed with a New Episode of Major Depressive Disorder during the Intake Period and treated with antidepressant medication.</p> <p>Step 1: Identify all patients with a diagnosis of depression who, during the 12-month Intake Period had:</p> <ul style="list-style-type: none"> <li>■ At least one principal diagnosis of major depression in any setting</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ At least two secondary diagnoses of major depression on different dates of service in any outpatient setting</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ At least one secondary diagnosis of major depression associated with any inpatient discharge.</li> </ul> <p>Codes to identify Major Depression: ICD-9 Codes: 296.2, 296.3, 298.0, 300.4, 309.1, 311; DRG Codes: 426*</p> <p>Prior Depressive Episodes: ICD-9 Codes: 296.2-296.9, 298.0, 300.4, 309.0, 309.1, 309.28, 311; DRG Codes: 426* (*exclude patients with this code if the principal diagnosis is ICD-9 CM Code 301.12).</p> <p>Step 2: Determine the Index Episode Start Date and test for negative diagnosis history. For each patient identified in step 1, determine the Index Episode Start Date by finding the date of the patient's earliest encounter during the Intake Period with a qualifying major depression diagnosis.</p>	<p>Risk adjustment is not applied; although the measure is collected for the specific age cohort 18 years and older. See numerators and denominators above for inclusions and exclusions. Definitions are as follows:</p> <p><b>Intake Period:</b> The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year. Used to capture New Episodes of treatment.</p> <p><b>Index Episode Start Date:</b> The earliest episode during the Intake Period with a qualifying diagnosis of major depression.</p> <p><b>Index Prescription Date:</b> The earliest prescription for antidepressants filled within a 44-day period, defined as 30 days prior to through 14 days on or after the Index Episode Start Date.</p> <p><b>Negative diagnosis history:</b> A period of 120 days (4 months) on or before the Index Episode Start Date, during which time the patient had no claims/encounters containing either a principal or secondary diagnosis of depression.</p> <p><b>Negative medication history:</b> A period of 90 days (3 months) prior to the Index Prescription Date, during which time the patient had no new or refill prescriptions for a listed antidepressant drug.</p> <p><b>New Episode:</b> To qualify as a new episode, two criteria must be met:</p> <p>(more)</p>	<p>The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for mental health visits (inpatient and ambulatory), procedures, and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>b. Effective Acute Phase Treatment</b> <i>continued</i>		<p>Antidepressant medications prescriptions (NQCA will provide a comprehensive list of medications and NDC Codes on its web site)</p> <ul style="list-style-type: none"> <li>■ Tricyclic antidepressants (TCA) and other cyclic antidepressants</li> <li>■ Selective serotonin reuptake inhibitors (SSRI)</li> <li>■ Monoamine oxidase inhibitors (MAOI)</li> <li>■ Serotonin-norepinephrine reuptake inhibitors (SNRI)</li> <li>■ Other antidepressants.</li> </ul> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator b:</b> Effective acute phase treatment (medical record)</p> <p>An 84-day (12-week) acute treatment of antidepressant medication.</p> <p>Identify all patients in the denominator population who have sufficient documentation in their medical record of a sufficient number of separate prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 84 days. The continuous treatment definition allows gaps in medication treatment up to a total of 30 days during the 84-day period. Allowable medication changes or gaps include:</p>	<p>Identify patients who were diagnosed with a New Episode of depression. Patients with a New Episode of depression are those who have a negative diagnosis history. The range of ICD-9-CM Diagnosis Codes for prior depressive episodes listed is more comprehensive to exclude patients diagnosed with any type of depression. Patients with any diagnosis of depression within the previous 120 days (4 months) of the Index Episode Start Date should be dropped from this denominator.</p> <p>Step 3: Identify patients receiving antidepressant medication therapy. Among patients identified in step 2, find those who filled a prescription for an antidepressant medication within 30 days before the Index Episode Start Date or 14 days on or after the Index Episode Start Date.</p> <p>Step 4: Identify the Index Prescription Date. Identify the earliest prescription up to 30 days before the Index Episode Start Date to 14 days on or after the Index Episode Start Date. Prescriptions may be up to 30 days before the Index Episode Start Date to account for patients having a recurrent episode who may be started on medication based on a phone encounter while awaiting a scheduled office visit. Similarly, prescriptions may be 14 days on or after the Index Episode Start Date to account for either clinical discretion in recommending a 2-week trial of self-help techniques prior to starting on medication or for patient delay in filling the initial prescription.</p> <p>Step 5: From the resulting patients from step 4, confirm the New Episode by testing for a negative</p>	<p>■ A 120-day (4-month) negative diagnosis history on or before the Index Episode Start Date.</p> <p>■ A 90-day (3-month) negative medication history on or before the Index Prescription Date.</p> <p><b>Prescribing Practitioner:</b> A practitioner with prescribing privileges.</p> <p>Treatment days: The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval.</p>	<p>for determination of the numerator.</p> <p>As noted in the measure description, those practices that have electronic health records system can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>b. Effective Acute Phase Treatment</b> <i>continued</i>		<ul style="list-style-type: none"> <li>■ “Washout” period gaps to change medication</li> <li>■ “Treatment” gaps to refill the same medication.</li> </ul> <p>Regardless of the number of gaps, the total gap days may be no more than 30 days. Any combination of gaps may be counted (e.g., two washout gaps, each 15 days, or two washout gaps of 10 days each and one treatment gap of 10 days). The total gap days may not exceed 30 days. To determine continuity of treatment during the 84-day period, sum the number of gap days to the number of treatment days for a maximum of 114 days (i.e., 84 treatment days + 30 gap days = 114 days). For all prescriptions prescribed within 114 days of the Index Prescription Date, count treatment days from the Index Prescription Date and continue to count until a total of 84 treatment days has been established. Patients whose gap days exceed 30 or who do not have 84 treatment days within 114 days after the Index Prescription Date are not counted in the numerator.</p> <p>Antidepressant medication prescriptions: (NQCA will provide a comprehensive list of medications and NDC Codes on its web site):</p> <ul style="list-style-type: none"> <li>■ Tricyclic antidepressants (TCA) and other cyclic antidepressants</li> <li>■ Selective serotonin reuptake inhibitors (SSRI)</li> <li>■ Monoamine oxidase inhibitors (MAOI)</li> <li>■ Serotonin-norepinephrine reuptake inhibitors (SNRI)</li> <li>■ Other antidepressants.</li> </ul>	<p>Medication history: Patients who have anti-depressant prescriptions filled during the negative medication history period do not represent new treatment episodes and must be excluded.</p> <p>Step 6: Exclude patients who had an acute mental health or substance abuse inpatient stay during the 245 days after the Index Episode Start Date treatment period.</p> <p>Codes to identify mental health inpatient services: DRG Codes: 424-432 except discharges with ICD-9 principle diagnosis of 317-319 ICD-9 CM Codes: 290, 293-302, 306-316 Codes to identify Chemical Dependency Inpatient services: DRG Codes: 433, 521-523 ICD-9 CM Codes: 291-292, 303-305, 960-979 with a secondary diagnosis of chemical dependency.</p> <p><b>Denominator for Numerators a, b, c (medical record):</b> A systematic sample of patients 18 years and older as of April 30 of the measurement year diagnosed with a New Episode of Major Depressive Disorder during the Intake Period and who were prescribed antidepressant medication.</p> <p>Step 1: Identify all patients with a diagnosis of depression who during the 12-month Intake Period had:</p> <ul style="list-style-type: none"> <li>■ At least one principal diagnosis of major depression in any setting</li> <li>■ At least two secondary diagnoses of major depression on different dates of service in any outpatient setting</li> </ul>	(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
b. Effective Acute Phase Treatment <i>continued</i>			<p>OR</p> <ul style="list-style-type: none"> <li>■ At least one secondary diagnosis of major depression associated with any inpatient discharge.</li> </ul> <p>Step 2: Determine the Index Episode Start Date and test for negative diagnosis history. For each patient identified in step 1, determine the Index Episode Start Date by finding the date of the patient's earliest encounter during the Intake Period with a qualifying major depression diagnosis.</p> <p>Identify patients who were diagnosed with a New Episode of depression. Patients with a New Episode of depression are those who have a negative diagnosis history. Patients with any diagnosis of depression within the previous 120 days (4 months) of the Index Episode Start Date should be dropped from this denominator.</p> <p>Step 3: Identify patients prescribed antidepressant medication therapy. Among patients identified in step 2, find those who have a prescription for an antidepressant medication within 30 days before the Index Episode Start Date or 14 days on or after the Index Episode Start Date.</p> <p>Step 4: Identify the Index Prescription Date.</p> <p>Identify the earliest written prescription up to 30 days before the Index Episode Start Date to 14 days on or after the Index Episode Start Date. Prescriptions may be up to 30 days before the Index Episode Start Date to account for patients having a recurrent episode who may be started on medication based on a phone encounter while awaiting a scheduled office visit. Similarly, written</p>	(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>b. Effective Acute Phase Treatment</b> <i>continued</i>			<p>prescriptions may be 14 days on or after the Index Episode Start Date to account for either clinical discretion in recommending a 2-week trial of self-help techniques prior to starting on medication.</p> <p>Step 5: From the resulting patients from step 4, confirm the New Episode by testing for a negative medication history. Patients who have antidepressant prescriptions written during the negative medication history period do not represent new treatment episodes and must be excluded.</p> <p>Step 6: Exclude patients who had an acute mental health or substance abuse inpatient stay during the 245 days after the Index Episode Start Date treatment period.</p>		
<b>c. Effective Continuation Phase Treatment</b>	NCQA <sup>2,4</sup>	<p><b>Numerator c:</b> Effective continuation phase treatment (electronic): A 180-day treatment of antidepressant medication.</p> <p>Identify all patients in the denominator population who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 180 days. The continuous treatment definition allows gaps in medication treatment up to a total of 51 days during the 180-day period. Allowable medication changes or gaps include:</p> <ul style="list-style-type: none"> <li>■ “Washout” period gap to change medication</li> <li>■ “Treatment” gaps to refill the same medication.</li> </ul> <p>Regardless of the number of gaps, the total gap days may be no more than 51 days. Any combination of gaps may be counted (e.g., two washout gaps, each 25 days or two washout gaps of 0 days</p>	<p><b>Denominator for rates a, b, c (electronic):</b> Patients 18 years and older as of April 30 of the measurement year diagnosed with a New Episode of Major Depressive Disorder during the Intake Period and treated with antidepressant medication.</p> <p>Step 1: Identify all patients with a diagnosis of depression who during the 12-month Intake Period had:</p> <ul style="list-style-type: none"> <li>■ At least one principal diagnosis of major depression in any setting</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ At least two secondary diagnoses of major depression on different dates of service in any outpatient setting</li> </ul> <p>OR</p>	<p>Risk adjustment is not applied; although the measure is collected for the specific age cohort 18 years and older. See numerators and denominators above for inclusions and exclusions. Definitions are as follows:</p> <p><b>Intake Period:</b> The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year. Used to capture New Episodes of treatment.</p> <p><b>Index Episode Start Date:</b> The earliest episode during the Intake Period with a qualifying diagnosis of major depression.</p> <p><b>Index Prescription Date:</b> The earliest prescription for antidepressants filled within a 44-day period, defined as 30 days prior to through 14 days on or after the Index Episode Start Date.</p>	<p>The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for mental health visits (inpatient and ambulatory), procedures, and pharmacy. The medical record option requires (more)</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>c. Effective continuation phase treatment</b> <i>continued</i>		<p>each and one treatment gap of 10 days). Total gap days may not exceed 51 days.</p> <p>To determine continuity of treatment during the 180-day period, sum the number of allowed gap days to the number of treatment days for a maximum of 231 days (i.e., 180 treatment days + 51 gap days = 231 days); identify all prescriptions filled within the 231 days of the Index Prescription Date.</p> <p>Count treatment days from the Index Prescription Date and continue to count until a total of 180 treatment days has been established. Patients whose gap days exceed 51 or who do not have 180 treatment days within 231 days after the Index Prescription Date are not counted in the numerator.</p> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology on the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Numerator 3:</b> Effective continuation phase treatment (medical record).</p> <p>A 180-day treatment of antidepressant medication. Identify all patients in the denominator population who have sufficient documentation in their medical record of separate prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 180 days.</p>	<ul style="list-style-type: none"> <li>■ At least one secondary diagnosis of major depression associated with any inpatient discharge.</li> </ul> <p>Codes to identify Major Depression: ICD-9 Codes: 296.2, 296.3, 298.0, 300.4, 309.1, 311; DRG Codes: 426.*</p> <p>Prior depressive episodes: ICD-9 Codes: 296.2-296.9, 298.0, 300.4, 309.0, 309.1, 309.28, 311; DRG Codes: 426.* (* exclude patients with this code if the principal diagnosis is ICD-9-CM Code 301.12).</p> <p>Step 2: Determine the Index Episode Start Date and test for negative diagnosis history. For each patient identified in step 1, determine the Index Episode Start Date by finding the date of the patient's earliest encounter during the Intake Period with a qualifying major depression diagnosis. Identify patients who were diagnosed with a New Episode of depression. Patients with a New Episode of depression are those who have a negative diagnosis history. The range of ICD-9-CM Diagnosis Codes for prior depressive episodes listed is more comprehensive to exclude patients diagnosed with any type of depression. Patients with any diagnosis of depression within the previous 120 days (4 months) of the Index Episode Start Date should be dropped from this denominator.</p> <p>Step 3: Identify patients receiving antidepressant medication therapy. Among patients identified in step 2, find those who filled a prescription for an antidepressant medication within 30 days before the Index Episode Start Date or 14 days on or after the Index Episode Start Date.</p>	<p>Negative diagnosis history: A period of 120 days (4 months) on or before the Index Episode Start Date, during which time the patient had no claims/encounters containing either a principal or secondary diagnosis of depression.</p> <p>Negative medication history: A period of 90 days (3 months) prior to the Index Prescription Date, during which time the patient had no new or refill prescriptions for a listed antidepressant drug.</p> <p>New Episode: To qualify as a new episode, two criteria must be met:</p> <ul style="list-style-type: none"> <li>■ A 120-day (4-month) negative diagnosis history on or before the Index Episode Start Date</li> <li>■ A 90-day (3-month) negative medication history on or before the Index Prescription Date.</li> </ul> <p>Prescribing Practitioner: A practitioner with prescribing privileges.</p> <p>Treatment Days: The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval.</p>	<p>manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.</p> <p>As noted in the measure description, those practices that have electronic health records system can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p> <p>(more)</p>

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>c. Effective continuation phase treatment</b> <i>continued</i>		<p>The continuous treatment definition allows gaps in medication treatment up to a total of 51 days during the 180-day period. Allowable medication changes or gaps include:</p> <ul style="list-style-type: none"> <li>■ “Washout” period gap to change medication</li> <li>■ “Treatment” gaps to refill the same medication.</li> </ul> <p>Regardless of the number of gaps, the total gap days may be no more than 51 days. Any combination of gaps may be counted (e.g., two washout gaps, each 25 days or two washout gaps of 0 days each and one treatment gap of 10 days). Total gap days may not exceed 51 days.</p> <p>To determine continuity of treatment during the 180-day period, sum the number of allowed gap days to the number of treatment days for a maximum of 231 days (i.e., 180 treatment days + 51 gap days = 231 days); identify all prescriptions filled within the 231 days of the Index Prescription Date.</p> <p>Count treatment days from the Index Prescription Date and continue to count until a total of 180 treatment days has been established. Patients whose gap days exceed 51 or who do not have 180 treatment days within 231 days after the Index Prescription Date are not counted in the numerator.</p>	<p>Step 4: Identify the Index Prescription Date. Identify the earliest prescription up to 30 days before the Index Episode Start Date to 14 days on or after the Index Episode Start Date. Prescriptions may be up to 30 days before the Index Episode Start Date to account for patients having a recurrent episode who may be started on medication based on a phone encounter while awaiting a scheduled office visit. Similarly, prescriptions may be 14 days on or after the Index Episode Start Date to account for either clinical discretion in recommending a 2-week trial of self-help techniques prior to starting on medication or for patient delay in filling the initial prescription.</p> <p>Step 5: From the resulting patients from step 4, confirm the New Episode by testing for a negative medication history. Patients who have antidepressant prescriptions filled during the negative medication history period do not represent new treatment episodes and must be excluded.</p> <p>Step 6: Exclude patients who had an acute mental health or substance abuse inpatient stay during the 245 days after the Index Episode Start Date treatment period.</p> <p>Codes to identify mental health inpatient services: DRG Codes: 424-432 except discharges with ICD-9 principal diagnosis of 317-319; ICD-9 CM Codes: 290, 293-302, 306-316; Codes to identify chemical dependency inpatient services: DRG Codes: 433, 521-523; ICD-9 CM Codes: 291-292, 303-305, 960-979 with a secondary diagnosis of chemical dependency.</p>	(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>c. Effective continuation phase treatment</b> <i>continued</i>			<p>Denominator for Numerators a, b, c (medical record): A systematic sample of patients 18 years and older as of April 30th of the measurement year diagnosed with a New Episode of Major Depressive Disorder during the Intake Period and who were prescribed antidepressant medication.</p> <p>Step 1: Identify all patients with a diagnosis of depression who, during the 12-month Intake Period had:</p> <ul style="list-style-type: none"> <li>■ At least one principal diagnosis of major depression in any setting</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ At least two secondary diagnoses of major depression on different dates of service in any outpatient setting</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ At least one secondary diagnosis of major depression associated with any inpatient discharge.</li> </ul> <p>Step 2: Determine the Index Episode Start Date and test for negative diagnosis history. For each patient identified in step 1, determine the Index Episode Start Date by finding the date of the patient's earliest encounter during the Intake Period with a qualifying major depression diagnosis.</p> <p>Identify patients who were diagnosed with a New Episode of depression. Patients with a New Episode of depression are those who have a negative diagnosis history. Patients with any diagnosis of depression within the previous 120 days (4 months) of the Index Episode Start Date should be dropped from this denominator.</p>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>c. Effective continuation phase treatment</b> <i>continued</i>			<p>Step 3: Identify patients prescribed antidepressant medication therapy. Among patients identified in step 2, find those who have a prescription for an antidepressant medication within 30 days before the Index Episode Start Date or 14 days on or after the Index Episode Start Date.</p> <p>Step 4: Identify the Index Prescription Date. Identify the earliest written prescription up to 30 days before the Index Episode Start Date to 14 days on or after the Index Episode Start Date. Prescriptions may be up to 30 days before the Index Episode Start Date to account for patients having recurrent episode who may be started on medication based on a phone encounter while awaiting a scheduled office visit. Similarly, written prescriptions may be 14 days on or after the Index Episode Start Date to account for either clinical discretion in recommending a 2-week trial of self-help techniques prior to starting on medication.</p> <p>Step 5: From the resulting patients from step 4, confirm the New Episode by testing for a negative medication history. Patients who have antidepressant prescriptions written during the negative medication history period do not represent new treatment episodes and must be excluded.</p> <p>Step 6: Exclude patients who had an acute mental health or substance abuse inpatient stay during the 245 days after the Index Episode Start Date treatment period.</p>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>DIAGNOSIS OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) IN PRIMARY CARE FOR CHILDREN AND ADOLESCENTS</b>	ICSI	<p>Number of medical records of newly diagnosed attention deficit hyperactivity disorder (ADHD) patients with documentation of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual for Primary Care (DSM-PC) criteria being addressed.*</p> <p>*Documented is defined as any evidence in the medical record that DSM-IV or DSM-PC criteria were addressed. DSM-IV or DSM-PC criteria include evaluation for:</p> <ul style="list-style-type: none"> <li>■ Symptoms</li> <li>■ Onset</li> <li>■ Duration</li> <li>■ Pervasiveness</li> <li>■ Impairment.</li> </ul> <p><i>Note:</i> The supporting ICSI clinical practice guideline provides a list of symptoms and specifies that six or more of the symptoms must be present for at least 6 months to a degree that is maladaptive and inconsistent with developmental level in order to qualify as ADHD.</p>	<p>Total number of medical records of newly diagnosed ADHD patients reviewed.*</p> <p>*ADHD is defined as International Classification of Diseases, 9th Revision (ICD-9) Codes of 314.00 or 314.01. Newly diagnosed is defined as documented ADHD in past 6 months and no documentation of ADHD Codes in the previous 6 to 12 months.</p>	None.	Medical record (with administrative to identify denominator population).
<b>MANAGEMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER IN PRIMARY CARE FOR CHILDREN AND ADOLESCENTS</b>	ICSI	<p>Number of medical records of attention deficit hyperactivity disorder (ADHD) patients on first-line medication with documentation of a follow-up visit twice a year.</p> <p>*Documented is defined as any evidence in the medical record that a follow-up visit occurred in the past 12 months. A follow-up visit for ADHD includes documentation of the following twice a year: height, weight, a discussion of medication, a discussion of school progress, and a care plan should be identified.</p>	<p>Total number of ADHD patients on first-line medication whose medical records are reviewed.</p> <p>*ADHD is defined as International Classification of Diseases, 9th Revision (ICD-9) Codes of 314.00 or 314.01. Diagnosed is defined as documented ADHD in the past 6 to 12 months. First-line medications include: methylphenidate (Ritalin), dextroamphetamine (Dexedrine), and atomoxetine (Strattera).</p>	None.	Medical record (with administrative to identify denominator population).

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ATTENTION DEFICIT HYPERACTIVITY DISORDER: FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION DEFICIT/ HYPERACTIVITY MEDICATION (INITIATION AND CONTINUATION AND MAINTENANCE PHASES)</b>	NCQA <sup>2,4</sup>	<p>Rate 1: Electronic Collection-Initiation Phase Electronic Collection-Initiation Phase: Patients with at least one ambulatory setting follow-up visit with a practitioner with prescribing authority within 30 days after the Index Prescription Start Date. Use the codes below to identify the follow-up visit, this visit must be face-to-face with a practitioner. Do not count the Index Prescription Start Date visit as the initiation follow-up visit. Emergency room visits do not count toward the numerator.</p> <p>Codes to identify initiation follow-up visit: CPT Codes: 90801, 90802, 90804-90815, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 96100, 96110, 96111, 96115, 96116, 96118, 96150-96154, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99350, 99354-99355, 99383-99384, 99393-99394, 99401-99404</p> <p>HPCPs: G0155, G0176, G0177, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, S9484, S9485</p> <p>UB-92 Revenue Codes: Psychiatric visit: 0510, 0513, 0515, 0517, 0519-0523, 0529, 0900, 0902, 0903, 0905, 0907, 0909, 0910, 0914-0916, 0918, 0919, 0961, 0982, 0983, 0988 - require UB-92 Type of Bill Code: 13X, 71X, 73X, 76X.</p>	<p>Rate 1: Electronic Collection-Initiation Phase Children 6-12 years of age with an ambulatory ADHD prescription dispensed. The following steps should be followed to identify the eligible population:</p> <p>Step 1: Identify all children 6 years of age as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year who were dispensed an ADHD medication during the 12-month Intake Period. Use the ADHD medication list below to identify the medications to be included.</p> <p>Step 2: For each child identified in Step 1; test each ADHD prescription for a negative medication history. The Index Prescription Episode Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a negative medication history.</p> <p>Step 3: Exclude patients who had an acute mental health or substance abuse inpatient stay during the 30 days after the Index Prescription Start Date.</p> <p>ADHD medication list:</p> <ul style="list-style-type: none"> <li>■ Methylphenidate—short-acting, intermediate-acting, extended release</li> <li>■ Dextroamphetamine—short-acting, extended release</li> <li>■ Mixed-salts amphetamine—short-acting, extended release</li> <li>■ Dexmethylphenidate</li> <li>■ Atomoxetine</li> <li>■ Methamphetamine HCL</li> </ul>	<p>See numerator and denominator descriptions above. Patients diagnosed with narcolepsy (ICD-9-CM Code: 347) should be excluded from the denominators.</p>	<p>The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics, claims or encounter data for visits, and pharmacy. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator. Those practices (more)</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ATTENTION DEFICIT HYPERACTIVITY DISORDER: FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION DEFICIT/ HYPERACTIVITY MEDICATION (INITIATION AND CONTINUATION AND MAINTENANCE PHASES)</b> <small>continued</small>		<p>dispensed may opt to follow the medical record specifications below but produce data on 10% of their denominator population instead of a sample.</p> <p><b>Rate 2: Medical Record Collection-Initiation Phase:</b>  <b>Phase:</b> Children 6–12 years of age with an ambulatory ADHD prescription dispensed. The following steps should be followed to identify the eligible population:</p> <p>Step 1: Identify all children 6 years of age as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year who were dispensed an ADHD medication during the 12-month Intake Period.</p> <p>Step 2: For each child identified in Step 1; test each ADHD prescription date in the Intake Period for a negative medication history. The Index Prescription Episode Start Date is the prescription date of the earliest ADHD prescription in the Intake Period with a negative medication history.</p> <p>Step 3: Exclude patients who had an acute mental health or substance abuse inpatient stay during the 30 days after the Index Prescription Start Date. Use the codes below to identify follow-up visits; one of these visits may be conducted on the telephone with either a non-mental health or mental health practitioner. Do not count the Initiation Phase follow-up visit toward C&amp;M follow-up visits. Emergency visits do not count toward the numerator.</p> <p>Codes to identify initiation follow-up visit: CPT Codes: 90801, 90802, 90804-90815, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 96100, 96110, 96115, 96150-96154, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99350, 99354-99355, 99383-99384, 99393-99394, 99401-99404</p>		<p>that have electronic health records system can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>	

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>ATTENTION DEFICIT HYPERACTIVITY DISORDER: FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION DEFICIT/ HYPERACTIVITY MEDICATION (INITIATION AND CONTINUATION AND MAINTENANCE PHASES)</b>		UB-92 Revenue Codes: Psychiatric visit: 0510, 0513, 0515, 0517, 0519-0523, 0529, 0900, 0902, 0903, 0905, 0907, 0909, 0910, 0914-0916, 0918, 0919, 0961, 0982, 0983, 0988 - require UB-92 type of Bill Code: 13X, 71X, 73X, 76X Telephone visits: 99371-99373.  <b>Rate 4: Medical Record Collection-C&amp;M Phase</b> Medical Record Collection: Continuation and Maintenance (C&M) Phase Patients who were compliant for the Initiation Phase AND had at least two follow-up visits with a practitioner from 31 through 300 days after the Index Prescription Start Date. One of these visits may be conducted on the telephone with either a non-mental health or mental health practitioner. Do not count the Initiation Phase follow-up visit toward C&M follow-up visits. Emergency visits do not count toward the numerator.	Step 2: For each patient identified in Step 1, the continuous medication treatment definition allows gaps in medication treatment up to a total of 90 days during the 300-day (10 month) period. This period spans the Initiation Phase (1 month) and the C&M Phase (9 months). Allowable medication changes or gaps include: <ul style="list-style-type: none"> <li>■ "Washout" period gaps to change medication</li> <li>■ "Treatment" gaps to refill the same medication</li> <li>■ "Drug holidays" from stimulant medication.</li> </ul> Regardless of the number of gaps, the total gap may be no more than 90 days. Any combination of gaps may be counted (e.g., 1 washout gap of 14 days and numerous weekend drug holidays). Step 3: Exclude patients who had an acute mental health or substance abuse inpatient stay during the 300 days after the Index Prescription Start Date.  <b>Medical Record Collection-C&amp;M Phase</b> Children 6 - 12 years of age who during the 12-month Intake Period had at least one dispensing event for an ADHD medication (drug list above). Follow the steps below to identify the eligible population for the C&M Phase. Step 1: Identify all patients who meet the eligible patient population criteria for the Initiation Phase rate. Step 2: For each patient identified in Step 1, the continuous medication treatment definition allows gaps in medication treatment up to a total of 90 days during the 300-day (10 month) period.	(more)	

*continued*

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
ATTENTION DEFICIT HYPERACTIVITY DISORDER: FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION DEFICIT/ HYPERACTIVITY MEDICATION (INITIATION AND CONTINUATION AND MAINTENANCE PHASES) <i>continued</i>			This period spans the Initiation Phase (1 month) and the C&M Phase (9 months). Allowable medication changes or gaps include: ■ “Washout” period gaps to change medication ■ “Treatment” gaps to refill the same medication ■ “Drug holidays” from stimulant medication. Regardless of the number of gaps, the total gap may be no more than 90 days. Any combination of gaps may be counted (e.g., 1 washout gap of 14 days and numerous weekend drug holidays). Step 3: Exclude patients who had an acute mental health or substance abuse inpatient stay during the 300 days after the Index Prescription Start Date.		(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>BIPOLAR DISORDER AND MAJOR DEPRESSION: ASSESSMENT FOR MANIC OR HYPOMANIC BEHAVIORS</b>	STABLE <sup>10</sup>	<p>Documentation of an assessment that considers the presence or absence of current and/or prior symptoms or behaviors of mania or hypomania. Sources of documentation may include the following:</p> <ul style="list-style-type: none"> <li>■ Documentation of presence or absence of the symptoms/behaviors associated with mania/ hypomania (Reference List of Symptoms/ Behaviors of Mania or Hypomania included in data collection form)</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ Use of a bipolar disorder screening or assessment tool: <ul style="list-style-type: none"> <li>● Clinical Global Impression - Bipolar</li> <li>● MDDQ: Mood Disorder Questionnaire</li> <li>● BDSS: Bipolar Spectrum Diagnostic Scale</li> <li>● YMRS: Young Mania Rating Scale</li> <li>● BDSS: Brief Bipolar Disorder Symptom Scale</li> <li>● Hypomanic Personality Scale</li> <li>● Self Report Mania Inventory</li> <li>● Altman Self Report Mania Scale</li> <li>● Bech-Rafaelson Mania Rating Scale</li> </ul> </li> </ul>	<p>Patients 18 years of age or older with an initial diagnosis or new presentation/episode of depression AND</p> <p>Documentation of a diagnosis of depression; to include at least one of the following:</p> <ul style="list-style-type: none"> <li>■ Codes 296.2K; 296.3X.300.4 or 311 (ICD9CM or DSM-IV-TR) documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms.</li> <li>■ Diagnosis or impression or “working diagnosis” documented in chart indicating depression.</li> <li>■ Use of a screening/assessment tool for depression with a score or conclusion that patient is depressed and documentation that this information is used to establish or substantiate the diagnosis</li> </ul> <p>AND</p> <p>Documentation of treatment for depression; to include at least one of the following: Antidepressant pharmacotherapy (Reference List of Antidepressant Medications included in data collection form)</p>	<p>None. “New diagnosis” or “new episode” is defined as cases where the patient has not been involved in active treatment for 6 months. Active treatment includes being hospitalized or under the outpatient care of a physician.</p> <p><i>Note: Measure denominator lends itself to administrative database identification through the use of patient age qualifiers and the codes specified in the denominator with the addition of pharmacy billing codes for antidepressant prescription therapy and/or psychotherapy.</i></p> <p>(more)</p>	<p>Measure was developed for and tested using medical chart review.</p>

<sup>10</sup> The STABLE Project is a physician-led quality improvement initiative to develop evidence-based clinical performance measures for bipolar disorder. The STABLE Project owns the measures; however, the co-chairs and National Coordinating Council members declared that all work products of the STABLE Project are NOT to be proprietary. The STABLE Project measures the development process to produce the measures, and any related resource tools are to be fully transparent and made available in the public domain. The STABLE Project has been provided with sponsoring funds from AstraZeneca; however, no representative of AstraZeneca has been present at or involved in any STABLE meeting, including any meetings involving co-chairs of the Project. AstraZeneca has had no involvement with or influence on the development, testing, or data analysis related to the STABLE Project. Likewise, the STABLE Project operates under an Agreement that the STABLE clinical performance measures will NOT be owned by AstraZeneca and will not be “branded” in any manner by AstraZeneca. The STABLE Project co-chairs, medical advisor, and members of the STABLE National Coordinating Council developed the measures. Technical assistance and project management services were provided by EPI-Q, Inc., a clinical consulting company. The STABLE Project co-chairs, medical advisor, and members of the STABLE National Coordinating Council will maintain the measures using a process to review the clinical literature, revisions, or new editions of relevant clinical guidelines, and any new medical breakthroughs (medical device, new technology, and/or pharmacology) that are supported by well-developed clinical trials. The review and maintenance process will be conducted as the former information becomes available or in a period not to exceed three years, whichever occurs first. Additionally, it is the goal of the STABLE Project co-chairs and STABLE NCC members to join with a permanent entity in maintaining the measures, providing that entity will contractually agree to maintain the measures as non-proprietary; non-branded; and scientific according to the objectives of the STABLE Project.

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>BIPOLAR DISORDER AND MAJOR DEPRESSION: ASSESSMENT FOR MANIC OR HYPOMANIC BEHAVIORS</b> <i>continued</i>		<i>OR</i> Other scale used and documented at site <i>AND</i> Timeframe for chart documentation of the assessment for mania/hypomania must be present prior to, or concurrent with, the visit where the treatment plan is documented as being initiated.	<i>AND/OR</i> Psychotherapy for depression; provided at practice site or through referral.		This will be considered in Phase II of continued development/maintenance.
<b>BIPOLAR DISORDER AND MAJOR DEPRESSION: APPRAISAL FOR ALCOHOL OR CHEMICAL SUBSTANCE USE</b>	STABLE <sup>10</sup>	Documented assessment for use of alcohol and chemical substance use; to include <u>at least one</u> of the following: <ul style="list-style-type: none"> <li>■ Clinician documentation regarding presence or absence of alcohol and chemical substance use</li> <li>■ Patient completed history/assessment form that addresses alcohol and chemical substance use that is documented as being acknowledged by clinician performing the assessment</li> <li>■ Use of screening tools that address alcohol and chemical substance use</li> </ul> <i>AND</i> Timeframe for chart documentation of the assessment for alcohol/chemical substance use must be present prior to, or concurrent with, the visit where the treatment plan is documented as being initiated.	Unipolar Depression Patients 18 years of age or older with an initial diagnosis or new presentation/episode of depression <i>AND</i> Documentation of a diagnosis of depression: include at least one of the following: Codes 296.2X; 296.3X; 300.4 or 311 (ICD-9-CM or DSM-IV-TR) documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms such as a problem list <i>OR</i> Diagnosis or impression or working diagnosis documented in chart indicating depression	None. “New diagnosis” or “new episode” is defined as cases where the patient has not been involved in active treatment for 6 months. Active treatment includes being hospitalized or under the outpatient care of a physician.	Measure was developed for cases where the patient has not been involved in active treatment for 6 months. Active treatment includes being hospitalized or under the outpatient care of a physician. <i>Note:</i> Measure denominator lends itself to administrative database identification through the use of patient age qualifiers and the codes specified in the denominator with the addition of pharmacy billing codes for relevant pharmacotherapy.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>BIPOLAR DISORDER AND MAJOR DEPRESSION: APPRAISAL FOR ALCOHOL OR CHEMICAL SUBSTANCE USE</b> <i>continued</i>			<p>Bipolar Disorder Patients 18 years of age or older with an initial or new episode of bipolar disorder <i>AND</i></p> <p>Documentation of a diagnosis of bipolar disorder; to include at least one of the following:</p> <ul style="list-style-type: none"> <li>■ Codes 296.0X; 296.1X; 296.4X; 296.5X; 296.6X; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ Diagnosis or impression or “working diagnosis” documented in chart indicating bipolar disorder</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and documentation that this information is used to establish or substantiate the diagnosis.</li> </ul>		<p>This will be considered in Phase II of continued development/maintenance.</p>
<b>BIPOLAR DISORDER: APPRAISAL FOR RISK OF SUICIDE</b>	STABLE <sup>10</sup>	Documentation of an assessment for risk of suicide; to include at least one of the following <sup>11</sup> :	<p>Patients 18 years of age or older with an initial or new episode of bipolar disorder <i>AND</i></p> <p>Documentation of a diagnosis of bipolar disorder; to include at least one of the following:</p> <ul style="list-style-type: none"> <li>■ ICD Codes 296.0X; 296.1X; 296.4X; 296.5X; 296.6X; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as</li> </ul>	<p>None. “New diagnosis” or “a new episode” is defined as cases where the patient has not been involved in active treatment for 6 months. Active treatment includes being hospitalized or under the outpatient care of a physician.</p> <ul style="list-style-type: none"> <li>■ ICD Codes 296.0X; 296.1X; 296.4X; 296.5X; 296.6X; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as</li> </ul>	<p>Measure was developed for and tested using medical chart review.</p> <p><i>Note:</i> Measure denominator lends itself to administrative (more)</p>

<sup>11</sup> During harmonization discussion, the measure developer noted that the intent of this measure is to conform to the American Psychiatric Association’s guidelines for suicide risk assessment. Future iterations of the measure will include a reference to the American Psychiatric Association’s guidelines.

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>BIPOLAR DISORDER: APPRAISAL FOR RISK OF SUICIDE</b> <i>continued</i>		form that addresses suicide (e.g., PHQ-9; Beck Hopelessness Scale; Beck Scale for Suicide) AND Timeframe for chart documentation of the assessment for risk of suicide must be present on the date of the initial assessment/evaluation visit.	a pre-printed form completed by a clinician and/or codes documented in chart notes/forms <i>Or</i> ■ Diagnosis or impression or “working diagnosis” documented in chart indicating bipolar disorder	<i>Or</i> ■ Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and documentation that this information is used to establish or substantiate the diagnosis.	database identification through the use of patient age qualifiers and the codes specified in the denominator with the addition of pharmacy billing codes for relevant pharmacotherapy. This will be considered in Phase II of continued development/maintenance.
<b>BIPOLAR DISORDER: LEVEL-OF-FUNCTION EVALUATION</b>	STABLE <sup>10</sup>	Documentation of monitoring the patient's level-of-functioning in one of the following ways: ■ Patient self-report documented by clinician in record <i>Or</i> ■ Clinician documented review of patient-completed monitoring form/diary/tool	Patients 18 years of age or older with an initial or new episode of bipolar disorder <i>And</i> Documentation of a diagnosis of bipolar disorder; to include at least one of the following: ■ ICD Codes 296.0X; 296.1X; 296.4X; 296.5X; 296.6X; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms <i>Or</i> ■ Documentation in patient chart of the use of ONE level-of-functioning monitoring tool. Examples are as follows: <ul style="list-style-type: none"><li>• SOFAS: Social and Occupational Functioning Assessment Scale</li></ul>	None. “New diagnosis” or “new episode” is defined as cases where the patient has not been involved in active treatment for 6 months. Active treatment includes being hospitalized or under the outpatient care of a physician.	Measure was developed for and tested using medical chart review. <i>Note:</i> Measure denominator lends itself to administrative database identification through the use of patient age (more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>BIPOLAR DISORDER: LEVEL-OF-FUNCTION EVALUATION</b> <i>continued</i>		<ul style="list-style-type: none"> <li>• GARF: Global Assessment of Relationship Functioning</li> <li>• GAF: Global Assessment of Functioning</li> <li>• WASA: Workload and Social Adjustment Assessment</li> <li>• PDS: Progressive Deterioration Scale (functional impairment; activities of daily living)</li> <li>• PHQ-9: Question 2 (How difficult has it been for you...?)</li> <li>• SF 12 or SF 36</li> </ul>	<ul style="list-style-type: none"> <li>■ Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and documentation that this information is used to establish or substantiate the diagnosis</li> </ul> <p><i>AND</i></p> <p>Documentation of treatment for bipolar disorder with pharmacotherapy, mood stabilizing agent, and/or an antipsychotic agent.</p>		<p>qualifiers and the codes specified in the denominator with the addition of pharmacy billing codes for relevant pharmacotherapy. This will be considered in Phase II of continued development/maintenance.</p>

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>BIPOLAR DISORDER: ASSESSMENT FOR DIABETES</b>	STABLE <sup>10</sup>	<p>Assessment for diabetes must include documentation of one of the following:</p> <ul style="list-style-type: none"> <li>■ Reference in chart that test was ordered and results or information about results was obtained</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ Lab results filed in chart or available in patient's electronic medical record</li> </ul> <p>Reference: Tests used to screen/assess for diabetes:</p> <p>Preferred: Fasting plasma glucose; non-fasting plasma glucose; glucose tolerance also accepted: glycosylated hemoglobin (Hb A1c; glycated hemoglobin) Random glucose</p> <p>AND</p> <p>Timeframe: Test results/information from test conducted within 16 weeks after the initiation of a second-generation atypical antipsychotic agent</p> <p>OR</p> <p>Measurement exclusion from compliance issues, Numerator criteria not applicable and exclusion from compliance as stated below:</p> <ol style="list-style-type: none"> <li>1. Documentation by physician that test was not clinically indicated for this patient</li> </ol> <p>OR</p> <ol style="list-style-type: none"> <li>2. Documentation that test was requested but patient failed to comply with request to obtain test.</li> </ol>	<p>Denominator: Patients 18 years of age or older with an initial or new episode of bipolar disorder</p> <p>AND</p> <p>Documentation of a diagnosis of bipolar disorder, to include at least one of the following:</p> <ul style="list-style-type: none"> <li>■ Codes 296.0X; 296.1X; 296.4X; 296.5X; 296.6X; 296.7; 296.80; 296.81; 296.82; 296.89; 301.13 documented in body of chart, such as a pre-printed form completed by a clinician and/or codes documented in chart notes/forms and/or codes documented in chart notes/forms</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>■ Diagnosis or impression or "working diagnosis" documented in chart indicating bipolar disorder</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>■ Use of a screening/assessment tool for bipolar disorder with a score or conclusion that patient has bipolar disorder and documentation that this information is used to establish or substantiate the diagnosis</li> </ul> <p>OR</p> <p>Measurement exclusion from compliance issues, Numerator criteria not applicable and exclusion from compliance as stated below:</p> <ol style="list-style-type: none"> <li>1. Documentation by physician that test was not clinically indicated for this patient</li> </ol> <p>OR</p> <ol style="list-style-type: none"> <li>2. Documentation that test was requested but patient failed to comply with request to obtain test.</li> </ol>	<p>None. New diagnosis" or a "new episode" is defined as cases where the patient has not been involved in active treatment for 6 months. Active treatment includes being hospitalized or under the outpatient care of a physician.</p> <p><i>Note:</i> Measure denominator lends itself to administrative database identification through the use of patient age qualifiers and the codes specified in the denominator with the addition of pharmacy billing codes for relevant pharmacotherapy.</p> <p>Measure numerator lends itself to administrative database identification for health plans where patient records indicating a billing code for the various types of diabetes tests may be identified.</p> <p>(more)</p>	<p>Measure was developed for and tested using medical chart review.</p> <p><i>Note:</i> Measure denominator lends itself to administrative database identification through the use of patient age qualifiers and the codes specified in the denominator with the addition of pharmacy billing codes for relevant pharmacotherapy.</p> <p>Measure numerator lends itself to administrative database identification for health plans where patient records indicating a billing code for the various types of diabetes tests may be identified.</p> <p>(more)</p>

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>BIPOLAR DISORDER: ASSESSMENT FOR DIABETES</b> <i>continued</i>			Atypical antipsychotic agents: ■ Aripiprazole ■ Quetiapine ■ Clozapine ■ Risperidone ■ Olanzapine ■ Ziprasidone ■ Olanzapine-fluoxetine (combination)		This will be considered in Phase II of continued development/maintenance.
<b>INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT</b> <b>a. Initiation of Alcohol and Other Drug Dependence Treatment</b>	NCQA <sup>2,4</sup> WC	<b>METHOD 1: Electronic Data Collection</b> <b>a. Electronic Collection-Initiation of AOD Dependence Treatment:</b> Initiation of AOD treatment can occur: if the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment; or if the Index Episode was a detoxification, ED visit or outpatient visit, the patient must have a subsequent service within 14 days of the Index Episode Start Date to be considered initiated. ED and detoxification visits count only toward the denominator and should not be included as the initiation visit. <b>Step 1:</b> Identify all patients in the denominator population whose Index Episode Start Date was an inpatient discharge with a primary or secondary AOD diagnosis. This visit counts as the initiation event. <b>Step 2:</b> Identify all patients in the denominator whose Index Episode Start Date was an outpatient visit, detoxification visit or emergency department visit.	<b>a and b: Electronic Collection:</b> All patients who meet the following criteria and stratified by age group according to the age classifications below: ■ 13 years and older as of December 31 of the measurement year ■ Adolescent Age Band: 13-17 year-olds ■ Adult Age Bands: 18-25 years old, 26-24 years old, 35-64 years old, 65+ years old ■ Total. The following steps should be followed to identify the eligible population which is the denominator for this measure: <b>Step 1:</b> Identify all patients 13 years and older who: ■ Had an AOD outpatient claim/encounter or intermediate claim/encounter between January 1 and November 15 of the measurement year <i>OR</i> ■ Had a detoxification or ED visit between January 1 and November 15 of the measurement year	Adjustment variables: No risk adjustment is applied although the measure is stratified by age. The following definitions apply: Index Episode Start Date: either the discharge date of the earliest inpatient encounter or the service date of the earliest intermediate, emergency department (ED), or outpatient encounter between January 1 and November 15 of the measurement year with a qualifying diagnosis of AOD dependence. Intake Period: January 1 through November 15 of the measurement year. To ensure adequate opportunities for care to be initiated within 14 days of a new episode of care, and two subsequent visits occur within an additional 30 days after initiation (inclusive), the last 15 days of the measurement year are not included in the Intake Period. Negative diagnosis history: A period of 60 days prior to the Index Episode Start Date,	The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics and claims or encounter data for medical and chemical dependency visits. The medical record option requires manual or electronically coded data for visits or encounters to determine the sample, and access to either (more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT</b> <b>a. Initiation of Alcohol and Other Drug Dependence Treatment</b> <i>continued</i>		<p>Step 3: Use the codes below to determine if the patients in step 2 had an additional outpatient visit or inpatient admission with any AOD diagnosis within 14 days of the Index Episode Start Date (inclusive).</p> <p>Step 4: Exclude from the denominator patients whose initiation service was an inpatient stay with a discharge date after December 1.</p> <p><b>METHOD 2: Medical Record Collection</b></p> <p>Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on AOD encounters may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>a. Medical Record Collection:</b> Initiation of AOD dependence treatment: The number of patients with documentation that initiation of AOD treatment occurred through any of the following mechanisms. If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment, or if the Index Episode was a detoxification, ED visit or outpatient visit, the patient must have a subsequent service within 14 days of the Index Episode Start Date to be considered initiated.</p> <p>ED and detoxification visits count only toward the denominator and should not be included as the initiation visit.</p>	<p>Or</p> <ul style="list-style-type: none"> <li>■ Had an inpatient discharge between January 1 and November 15 of the measurement year.</li> </ul> <p>Outpatient visits: Use the following codes to identify intermediate and outpatient services with a principal or secondary diagnosis of AOD dependence:</p> <ul style="list-style-type: none"> <li>■ CPT Codes: 90801, 90802, 90804-90815, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870-90871, 90875, 90876, 99201-99705, 99211-99715, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99420.</li> <li>■ HCPCS: G0155, G1076, G0177, H0001, H0002, H0004-H0007, H0015, H0016, H0020, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S9480, S9484, S9485, T1006, T1012.</li> <li>■ ICD-9-CM Codes: 291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1.</li> </ul> <p>Detoxification and ED visits: Use the following codes to identify detoxification and ED visits with a principal or secondary diagnosis of AOD dependence. If the ED visit resulted in an inpatient stay, include the patient in the inpatient category.</p>	<p>written or electronic medical records to both confirm information in the sampling framework for the denominator and for determination of the numerator.</p> <p>As noted in the measure description, those practices that have electronic health records system can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>	(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT</b> <b>a. Initiation of Alcohol and Other Drug Dependence Treatment</b> <i>continued</i>		<p>Step 1: Identify all patients in the denominator population whose Index Episode Start Date was an inpatient discharge with a primary or secondary AOD diagnosis. This visit counts as the initiation event.</p> <p>Step 2: Identify all patients in the denominator whose Index Episode Start Date was an outpatient visit, detoxification visit or emergency department visit.</p> <p>Step 3: Determine if the patients in step 2 had an additional outpatient visit or inpatient admission with any AOD diagnosis within 14 days of the Index Episode Start Date (indisive).</p> <p>To determine if the 14-day criterion is met for inpatient stays, use the admission date, not the discharge date.</p> <p>Step 4: Exclude from the denominator patients whose initiation service was an inpatient stay with a discharge date after December 1.</p>	<ul style="list-style-type: none"> <li>■ CPT Codes: 99281-99285 with an ICD-9-CM Code from above</li> <li>■ HCPCS: H0008-H0014, S9475 with an ICD-9-CM Code from above</li> <li>■ UB-92 Revenue Codes: 0450, 0451, 0452, 0459 with an ICD-9-CM Code from above</li> <li>■ UB-92 Procedure Codes: 94.62, 94.63, 94.65, 94.66, 94.68, 94.69</li> <li>■ DRGs: 433, 521-523</li> <li>■ ICD-9-CM Principal Diagnosis Codes: 291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1 with an inpatient facility code.</li> </ul> <p>Step 2: For each patient identified in step 1, determine the Index Episode Start Date by identifying the date of the patient's earliest encounter during the measurement year (e.g., outpatient, detoxification or ED visit date, inpatient discharge date) with any qualifying AOD dependence diagnosis (see ICD-9-CM Principal Diagnosis list above).</p> <p>Step 3: Determine if the Index Episode Start Date is a New Episode. Patients with a New Episode of</p>	(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT</b> a. Initiation of Alcohol and Other Drug Dependence Treatment <i>continued</i>			<p>AOD dependence have a negative diagnosis history of 60 days without an AOD diagnosis. For patients with an inpatient visit, use the admission date to determine negative diagnosis history.</p> <p><b>a and b: Medical Record Collection:</b> All patients with documentation of meeting the following criteria and stratified by age group according to the age classifications below:</p> <ul style="list-style-type: none"> <li>■ 13 years and older as of December 31 of the measurement year</li> <li>■ Adolescent Age Band: 13-17 year-olds</li> <li>■ Adult Age Bands: 18-25 years old, 26-24 years old, 35-64 years old, 65+ years old</li> <li>■ Total.</li> </ul> <p>The following steps should be followed to identify the eligible population which is the denominator for this measure:</p> <p>Step 1: Identify all patients 13 years and older who:</p> <ul style="list-style-type: none"> <li>■ Had an outpatient claim/encounter or intermediate AOD claim/encounter between January 1 and November 15 of the measurement year</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ Had a detoxification or ED visit between January 1 and November 15 of the measurement year</li> <li>■ Had an inpatient discharge between January 1 and November 15 of the measurement year.</li> </ul>	(more)	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT</b> <i>a. Initiation of Alcohol and Other Drug Dependence Treatment</i> <i>(continued)</i>			Step 2: For each patient identified in step 1, determine the Index Episode Start Date by identifying the date of the patient's earliest encounter during the measurement year (e.g., outpatient, detoxification or ED visit date, inpatient discharge date) with any qualifying AOD dependence diagnosis.  Step 3: Determine if the Index Episode Start Date is a New Episode. Patients with a New Episode of AOD dependence have a negative diagnosis history of 60 days without an AOD diagnosis. For patients with an inpatient visit, use the admission date to determine negative diagnosis history.		The electronic data option requires use of data that is capable of being analyzed by computer including patient demographics and claims or encounter data for medical and chemical dependency visits. The medical record option requires manual or electronically coded data for (more)
<b>INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT</b> <i>b. Engagement of Alcohol and Other Drug Dependence Treatment</i>	NCQA <sup>2,4</sup> WC	<b>b: Electronic Collection:</b> Engagement of AOD Treatment: Identify patients who had an initiation of AOD treatment visit and two or more services with AOD dependence diagnosis within 30 days after the date of the initiation visit (inclusive). Use the codes below to identify engagement treatment:  For patients who initiated treatment via inpatient stay, 30 days starts at the patient's inpatient discharge date. To determine if the 30-day criterion is met for engagement inpatient stays, count days to the next outpatient service or the admission date of the subsequent inpatient stay, not the discharge date  ED and detoxification visits count only toward the denominators and should not be included as an engagement visit.  ■ Had an AOD outpatient claim/encounter or intermediate claim/encounter between January 1 and November 15 of the measurement year	<b>a and b: Electronic Collection:</b> All patients who meet the following criteria, and stratified by age group according to the age classifications below: ■ 13 years and older as of December 31 of the measurement year ■ Adolescent Age Band: 13-17 year-olds ■ Adult Age Bands: 18-25 years old, 26-24 years old, 35-64 years old, 65+ years old ■ Total.  The following steps should be followed to identify the eligible population which is the denominator for this measure: Step 1: Identify all patients 13 years and older who: ■ Had an AOD outpatient claim/encounter or intermediate claim/encounter between January 1 and November 15 of the measurement year	Adjustment variables: No risk adjustment is applied although the measure is stratified by age. The following definitions apply: Index Episode Start Date: Either the discharge date of the earliest inpatient encounter or the service date of the earliest intermediate, emergency department (ED), or outpatient encounter between January 1 and November 15 of the measurement year with a qualifying diagnosis of AOD dependence.  Intake Period: January 1 through November 15 of the measurement year. To ensure adequate opportunities for care to be initiated within 14 days of a new episode of care, and two subsequent visits occur within an additional 30 days after initiation (inclusive), the last 45 days of the measurement year are not included in the intake Period.	

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT</b> <b>b. Engagement of Alcohol and Other Drug Dependence Treatment</b> <i>continued</i>		<p><b>METHOD 2: Medical Record Collection</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on AOD encounters may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>b. Medical Record Collection:</b> Engagement of AOD Treatment: Identify patients who had documentation of an initiation of AOD treatment visit and two or more services with AOD dependence diagnosis within 30 days after the date of the initiation visit (inclusive). For patients who initiated treatment via inpatient stay, 30 days starts at the patient's inpatient discharge date. To determine if the 30-day criterion is met for engagement inpatient stays, count days to the next outpatient service or the admission date of the subsequent inpatient stay, not the discharge date ED and detoxification visits count only toward the denominator and should not be included as an engagement visit.</p>	<p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ Had a detoxification or ED visit between January 1 and November 15 of the measurement year</li> <li>■ Had an inpatient discharge between January 1 and November 15 of the measurement year.</li> </ul> <p>Outpatient visits: Use the following codes to identify intermediate and outpatient services with a principal or secondary diagnosis of AOD dependence:</p> <ul style="list-style-type: none"> <li>■ CPT Codes: 90801, 90802, 90804-90815, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870-90871, 90875, 90876, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 993341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99420 HPCS: G0155, G1076, G0177, H0001, H0002, H0004-H0007, H0015, H0016, H0020, H0031, H0034-H0037/H0039, H0040, H2000, H2001, H2010-H2020, H2035, M0064, S9480, S9484, S9485, T1006, T1012</li> <li>■ ICD-9-CM Codes: 291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.57, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1.</li> </ul>	<p>Negative diagnosis history: A period of 60 days prior to the Index Episode Start Date, during which the patient had no claims/encounters with any diagnosis of AOD dependence. If the Index Episode Start Date was an inpatient visit, use the admission date to determine the 60-day negative diagnosis history.</p> <p>New Episode: To qualify as a New Episode, the following criterion must be met: a 60-day negative diagnosis history prior to the Index Episode Start Date. If the Index Episode Start Date was an inpatient visit, use the admission date to determine the 60-day negative diagnosis history.</p> <p>Inpatient facility code: The place of service or facility code, indicating that care was provided at an inpatient facility.</p> <p>As noted in the measure description, those practices that have electronic health records system can use either electronic or medical record approach but include all eligible patients, rather than a sample, in both the denominator and numerator.</p>	(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT</b> <b>b. Engagement of Alcohol and Other Drug Dependence Treatment</b> <i>continued</i>			<p>Detoxification and ED visits: Use the following codes to identify detoxification and ED visits with a principal or secondary diagnosis of AOD dependence. If the ED visit resulted in an inpatient stay, include the patient in the inpatient category:</p> <ul style="list-style-type: none"> <li>■ CPT Codes: 99281-99285 with an ICD-9-CM Code from above</li> <li>■ HCPCS: H0008-H0014, S9475 with an ICD-9-CM Code from above</li> <li>■ UB-92 Revenue Codes: 0450, 0451, 0452, 0459 with an ICD-9-CM Code from above</li> <li>■ ICD-9 Procedure Codes: 94.62, 94.63, 94.65, 94.66, 94.68, 94.69</li> </ul> <p>Inpatient services: Use the following codes to determine if inpatient services with a principal or secondary diagnosis of AOD dependence:</p> <ul style="list-style-type: none"> <li>■ DRGs: 433, 521-523</li> <li>■ ICD-9-CM Principal Diagnosis Codes: 291-292, 303-304, 305.0, 305.2-305.9, 535.3, 571.1 with an inpatient facility code.</li> </ul> <p>Step 2: For each patient identified in step 1, determine the Index Episode Start Date by identifying the date of the patient's earliest encounter during the measurement year (e.g., outpatient, detoxification or ED visit date, inpatient discharge date) with any qualifying AOD dependence diagnosis (see ICD-9-CM Principal Diagnosis list above).</p>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT</b> <b>b. Engagement of Alcohol and Other Drug Dependence Treatment</b> <i>continued</i>			<p>Step 3: Determine if the Index Episode Start Date is a New Episode. Patients with a New Episode of AOD dependence have a negative diagnosis history of 60 days without an AOD diagnosis.</p> <p>For patients with an inpatient visit, use the admission date to determine negative diagnosis history.</p> <p><b>a and b: Medical Record Collection:</b> All patients with documentation of meeting the following criteria, and stratified by age group according to the age classifications below:</p> <ul style="list-style-type: none"> <li>■ 13 years and older as of December 31 of the measurement year</li> <li>■ Adolescent Age Band: 13–17 year-olds</li> <li>■ Adult Age Bands: 18–25 years old; 26–24 years old, 35–64 years old, 65+ years old</li> <li>■ Total.</li> </ul> <p>The following steps should be followed to identify the eligible population which is the denominator for this measure:</p> <p>Step 1: Identify all patients 13 years and older who:</p> <ul style="list-style-type: none"> <li>■ Had an outpatient claim/encounter or intermediate AOD claim/encounter between January 1 and November 15 of the measurement year <i>Or</i></li> <li>■ Had a detoxification or ED visit between January 1 and November 15 of the measurement year</li> </ul>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**MENTAL HEALTH AND SUBSTANCE USE DISORDERS (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT b. Engagement of Alcohol and Other Drug Dependence Treatment <i>continued</i>			<p><i>Or</i></p> <ul style="list-style-type: none"> <li>■ Had an inpatient discharge between January 1 and November 15 of the measurement year.</li> </ul> <p>Step 2: For each patient identified in step 1, determine the Index Episode Start Date by identifying the date of the patient's earliest encounter during the measurement year (e.g., outpatient, detoxification or ED visit date, inpatient discharge date) with any qualifying AOD dependence diagnosis.</p> <p>Step 3: Determine if the Index Episode Start Date is a New Episode. Patients with a New Episode of AOD dependence have a negative diagnosis history of 60 days without an AOD diagnosis. For patients with an inpatient visit, use the admission date to determine negative diagnosis history.</p>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

<b>OBESITY</b>					
<b>Measure</b>	<b>IP Owner<sup>1</sup></b>	<b>Numerator</b>	<b>Denominator</b>	<b>Exclusions</b>	<b>Data Source</b>
<b>BODY MASS INDEX IN ADULTS &gt;18 YEARS OF AGE</b>	NYC-DHMH	Adults > 18 years old with BMI documented in the past 24 months.	Total number of patients > 18 years old seen in the measurement period.	None.	Medical record.
<b>BODY MASS INDEX 2 THROUGH 18 YEARS OF AGE</b>	NICHD	Number of children 2 through 18 years of age who came in for a well child visit in the measurement period month and who were classified based on BMI percentile for age and gender.	Number of children 2 through 18 years of age, with a well child visit in the measurement period month.	None.	Medical record.

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### PRENATAL CARE

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>SCREENING FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV)</b>	AMA PCP <sup>2,3</sup>	Patients who were screened for HIV infection during the first or second prenatal care visit. CPT HIV-1: 87390 CPT HIV-2: 87391,87534-87539 LOINC Codes: 14092-1,24012-7,29893-5,31201-7,5221-7,5222-5,7917-8,7918-6.	All patients who gave birth during a 12-month period, seen for continuing prenatal care. ICD-9 Codes for pregnancy: V22.0-V23.9.	Documentation of medical reason(s) for not screening for HIV during the first or second prenatal care visit (e.g., patient has known HIV). Documentation of patient reason(s) for not screening for HIV during the first or second prenatal care visit.	EHRS, retrospective paper medical records, prospective flowsheet, administrative claims data.* *CPT Category II Codes in development.
<b>ANTI-D IMMUNE GLOBULIN</b>	AMA PCP <sup>2,3</sup>	Patients who received anti-D immunoglobulin at 26-30 weeks gestation. CPT Codes: 90384,90385,90386.	All patients who are D (Rh) negative and unsensitized who gave birth during a 12-month period, seen for continuing prenatal care. ICD-9 Codes for pregnancy: V22.0-V23.9.	Documentation of medical reason(s) for patient not receiving anti-D immune globulin at 26-30 weeks gestation. Documentation of patient reason(s) for patient not receiving anti-D immune globulin at 26-30 weeks gestation.	EHRS, retrospective paper medical records, prospective flowsheet, administrative claims data.* *CPT Category II Codes in development.
<b>BLOOD GROUPS (ABO), D (RH) TYPE</b>	AMA PCP <sup>2,3</sup>	Patients whose blood group (ABO) and D (Rh) type have been determined by the second prenatal care visit. CPT ABO: 86900 CPT Rh (D): 86901 LOINC Code: 34530-6 OR Physician documentation of prior laboratory results of blood group (ABO) and D (Rh) type.	All patients who gave birth during a 12-month period, seen for continuing prenatal care. ICD-9 Codes for pregnancy: V22.0-V23.9.	None.	EHRS, retrospective paper medical records, prospective flowsheet, administrative claims data.* *CPT Category II Codes in development.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PRENATAL CARE (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
BLOOD GROUP ANTIBODY TESTING	AMA PCP <sup>2,3</sup>	Patients who received blood group screening during the first or second prenatal care visit.  CPT Codes: 86650 LOINC Code: 890-4.	All patients who gave birth during a 12-month period, seen for continuing prenatal care.  ICD-9 Codes for pregnancy: V22.0-V23.9.	None.	EHRS, retrospective paper medical records, prospective flowsheet, administrative claims data.*  *CPT Category II Codes in development.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - TOBACCO USE**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>MEASURE PAR:</b> <b>a. Tobacco use prevention for infants, children, and adolescents</b>	ICSI	Number of patients' charts audited whose current tobacco status is documented in the medical record.	Total number of patients' charts audited.	Inclusions: Total number of patient charts audited. Exclusions: None. The measure applies to all patients visiting the practice, regardless of age, who have any indication on their charts that they are or may be users of tobacco, or in the case of children that they are regularly exposed to tobacco smoke.	Medical record.
<b>b. Tobacco use cessation for infants, children, and adolescents</b>	ICSI	Number of tobacco users advised to quit or whose readiness to quit was assessed at the latest visit.	Total number of tobacco users audited.	Inclusions: Total number of patient charts audited. Exclusions: None. The measure applies to all patients visiting the practice, regardless of age, who have any indication on their charts that they are or may be users of tobacco, or in the case of children that they are regularly exposed to tobacco smoke.	Medical record.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - TOBACCO USE (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>SMOKING CESSATION: MEDICAL ASSISTANCE</b>	NCQA <sup>2,4</sup>	<p><b>Numerator a:</b> Advising smokers to quit: The number of patients in the denominator who responded to the survey and indicated that they had received advice to quit smoking from a doctor or other health provider during the measurement year.</p> <p>Patient choices must be as follows to be included in the numerator:</p> <p>Q: In the last 12 months, on how many visits were you advised to quit smoking by a doctor or other health care provider?</p> <p>A: "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits" must be chosen from the options of "None" or "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits" or "I had no visits in the last 12 months."</p> <p><b>Numerator b:</b> Discussing smoking cessation medications: The number of patients in the denominator who responded to the survey and indicated that their doctor or other health provider recommended or discussed medications to assist with quitting smoking during the measurement year.</p> <p>Patient choices must be as follows to be included in the numerator:</p> <p>Q: On how many visits was medication recommended or discussed to assist you with quitting smoking (e.g., nicotine gum, patch, nasal spray, inhaler, prescription medicine)?</p> <p>A: "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits" must be chosen from the options of "None" or "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits."</p>	<p><b>Denominator:</b> The number of patients 18 and older who responded to the survey and indicated that they were current smokers and had one or more visits during the measurement year.</p> <p>Patient choices must be as follows to be included in the denominator:</p> <p>Q: Do you now smoke cigarettes every day, some days, or not at all?</p> <p>A: "Every day" or "Some days" must be chosen from the options of "Every day," "Some days," "Not at all," or "Don't know."</p> <p>Q: In the last 12 months, on how many visits were you advised to quit smoking by a doctor or other health professional?</p> <p>A: "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits" must be chosen from the options of "None" or "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits."</p>	<p>Exclusions: Patients who responded "I had no visits in the last 12 months" and who smoke cigarettes "not at all" are excluded.</p>	Patient survey.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - TOBACCO USE (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>SMOKING CESSATION: MEDICAL ASSISTANCE</b>		"10 or more visits" or "I had no visits in the last 12 months."  <b>Numerator c:</b> Discussing smoking cessation strategies: The number of patients in the denominator who responded to the survey and indicated that their doctor or health care provider recommended or discussed methods and strategies other than medication to assist with quitting smoking during the measurement year.  Patient choices must be as follows to be included in the numerator:  <b>Q:</b> On how many visits did your doctor or health provider discuss methods and strategies (other than medication) to assist you with quitting smoking?  <b>A:</b> "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits" must be chosen from the options of "None" or "1 visit" or "2-4 visits" or "5-9 visits" or "10 or more visits" or "I had no visits in the last 12 months."			

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - TOBACCO USE (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>MEASURE PAR:</b> <b>a. Tobacco use assessment</b>	AMA PCP <sup>2,3</sup>	Patients who were queried about tobacco use one or more times <i>OR</i> CPT II Codes: 1000F Tobacco use assessed <i>OR</i> report one of the following codes: 1034F Current tobacco smoker 1035F Current smokeless tobacco user (e.g., chew, snuff) 1036F Current tobacco non-user.	All patients $\geq 18$ years of age at the beginning of the two-year measurement period. Patient selection: CPT Codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 <i>AND</i> Patient's age is $\geq 18$ years.	None.	Electronic health record system (EHRs), administrative data using CPT II Codes, paper medical record, prospective flowsheet.
<b>b. Tobacco cessation intervention</b>	AMA-PCP <sup>2,3</sup>	Patients identified as tobacco users who received cessation intervention. Cessation intervention may include smoking cessation counseling (e.g., advise to quit, referral for counseling) and/or pharmacologic therapy. CPT II Codes: 4000F: Tobacco use cessation intervention, counseling; <i>OR</i> 4001F: Tobacco use cessation intervention, pharmacologic therapy.	All patients $\geq 18$ years of age identified as tobacco users at the beginning of the two-year measurement period. Patient selection: CPT Codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 <i>AND</i> ICD-9-CM Codes for tobacco user: 305.1 <i>OR</i> CPT II Codes: 1034F Current tobacco smoker; 1035F Current smokeless tobacco use (e.g., chew, snuff); 1036F Current tobacco non-user <i>OR</i> Individual medical record review must be completed to identify those patients who are tobacco users <i>AND</i> Patient's age is $\geq 18$ years.	None.	Electronic health record system (EHRs), administrative data using CPT II Codes, paper medical record, prospective flowsheet.

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### PREVENTION, IMMUNIZATION, AND SCREENING - GENERAL PREVENTION

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>PHYSICAL ACTIVITY IN OLDER ADULTS</b> <b>a. Discussing physical activity</b> <b>b. Advising physical activity</b>	NCQA <sup>2,4</sup>	<p>Survey Questions:</p> <ul style="list-style-type: none"> <li>■ In the last 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.</li> <li>• Yes, Go to next Question</li> <li>• No, Go to next Question</li> <li>• I had no visits in the last 12 months, Go to Question X.</li> </ul>	<p><b>Denominator a:</b> Discussing physical activity: The number of patients 65 years and older as of December 31 of the measurement year who responded "yes" or "no" to the question "In the last 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise."</p> <p><b>Denominator b:</b> Advising physical activity: The number of patients 65 years and older as of December 31 of the measurement year who responded "yes" or "no" to the question, "In the last 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day, or to maintain your current exercise program: Yes/No</p> <p><b>Numerator a:</b> Discussing physical activity: The number of patients in the denominator who responded "yes" to the question, "In the last 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise."</p>	<p>None.</p> <p>There are very few people for whom exercise and physical activity are contraindicated (for example, people with symptomatic aortic stenosis may be advised against strenuous physical activity)<sup>12</sup>; aortic stenosis affects about 3% to 5% of the elderly over 75; only half are symptomatic).</p> <p>The National Center for Physical Activity and Disability also recommends that people with disabilities exercise, since they are less active, and has developed a guide<sup>13</sup> advising disabled people to talk to a doctor before starting an exercise program and to discuss any possible effects of medications on exercising. Therefore this measure is also relevant to patients with disabilities.</p> <p>Exclusions may be considered in provider level settings who care exclusively for patients with severe limitations in activities of daily living. It is expected that only a very small percentage of community-dwelling respondents for whom questions on exercise and physical activity may potentially be less relevant, due to serious limitations and difficulty in being able to conduct activities of daily living (e.g., bathing, dressing, eating, getting in and out of chairs, walking, using the toilet) or other severe disabilities.</p> <p>National statistics<sup>14</sup> suggest that the</p>	Patient survey.  (more)

<sup>12</sup> Otto CM, Lind BK, Kitzm, DW, et al., for the Cardiovascular Health Study. Association of aortic valve sclerosis with cardiovascular mortality and morbidity in the elderly. *N Engl J Med*, 1999;341:142-147.

<sup>13</sup> National Center of Physical Activity and Disability. General Exercise Guidelines. Available at [www.ncpad.org/exercise/fact\\_sheet.php?sheet=15](http://www.ncpad.org/exercise/fact_sheet.php?sheet=15). Last accessed August 2006.

<sup>14</sup> Centers for Disease Control and Prevention, *Functional Limitation by Sex, Race – 1983–1996 [10-year age groups]*. National Health Interview Survey.

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - GENERAL PREVENTION (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>PHYSICAL ACTIVITY IN OLDER ADULTS</b>		Numerator b: Advising physical activity: The number of patients in the denominator who responded "yes" to the question, "In the last 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program."		majority of the elderly (83%) have no limitations, and only 6% indicate they need help with activities of daily living.	
<b>a. Discussing physical activity</b> <b>b. Advising physical activity</b> <i>continued</i>					
<b>URINARY INCONTINENCE MANAGEMENT IN OLDER ADULTS</b>	NCQA <sup>2,4</sup>	Numerator a: Discussing urinary incontinence: The number of patients in denominator a who indicated they discussed their urine leakage problem with their current provider. Patient choices must be as follows to be included in the numerator: Q: "In the last six months, have you talked with your current doctor or other health care provider about your urine leakage problem?" A: "Yes" must be chosen from the options of: "Yes" or "No" or "I did not see a doctor or health provider in the last six months." Numerator b: Receiving urinary incontinence treatment: The number of patients in denominator b who indicated they received treatment for their current urine leakage problem. Member choices must be as follows to be included in the numerator:	Denominator a: Discussing Urinary Incontinence: The number of patients 65 years and older who responded to the survey indicating they had a urine leakage problem in the last 6 months. Patient choices must be as follows to be included in the numerator: Q: "Many people experience problems with urinary incontinence, the leakage of urine. In the last six months, have you accidentally leaked urine?" A: "Yes" must be chosen from the options of: "Yes" or "No." Q: "How much of a problem, if any, was the urine leakage for you?" A: "A big problem" or "A small problem" must be chosen from the options of: "A big problem" or "A small problem" or "Not a problem." Denominator b: Receiving urinary incontinence treatment: The number of patients 65 years and older who responded to the survey indicating they had a urine leakage problem in the last 6 months	Exclusions: Patients who did not have a doctor's visit in the last year or who reported they did not have a problem with UI, are excluded.	Patient survey.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - GENERAL PREVENTION (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>URINARY INCONTINENCE MANAGEMENT IN OLDER ADULTS</b>		<p>Q: "There are many ways to treat urinary incontinence including bladder training, exercises, medication, and surgery. Have you received these or any other treatments for your current urine leakage problem?"</p> <p>A: "Yes" must be chosen from the options of "Yes" or "No."</p> <p>a. Discussing urinary incontinence</p> <p>b. Receiving urinary incontinence treatment</p> <p><i>continued</i></p>	<p>and discussed their urine leakage problem with their current provider.</p> <p>Member choices must be as follows to be included in the numerator:</p> <p>Q: "Many people experience problems with urinary incontinence, the leakage of urine. In the last six months, have you accidentally leaked urine?"</p> <p>A: "Yes" must be chosen from the options of "Yes" or "No."</p> <p>Q: "How much of a problem, if any, was the urine leakage for you?"</p> <p>A: "A big problem" or "A small problem" must be chosen from the options of: "A big problem" or "A small problem" or "Not a problem."</p> <p>Q: "In the last six months, have you talked with your doctor or other health provider about your current urine leakage problem?"</p> <p>A: "Yes" must be chosen from the options of: "Yes" or "No" or "I did not see a doctor or health provider in the last six months."</p>		(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### PREVENTION, IMMUNIZATION, AND SCREENING - SCREENING

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
BREAST CANCER SCREENING	NCQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> One or more mammograms during the measurement year or the year prior to the measurement year. (PT Codes: 76083, 76090-76092; ICD-9-CM Codes 87.36, 87.37; V-Codes: V76.11, V76.12; UB-92 Codes: 0403; HCPCS G0202)</p> <p><b>Medical Record Collection:</b> Numerator: One or more mammograms during the measurement year or the year prior to the measurement year. Documentation in the medical record must include both of the following: a note indicating the date the mammogram was performed and the result or finding.</p> <p>Electronic Health Record (EHR) users may opt to use record-based methodology or the electronic data collection methodology described above. EHR users may opt to follow the medical record specifications but produce data on 100% of their denominator population instead of a sample.</p>	<p><b>Electronic Collection:</b> Women 42-69 years as of December 31 of the measurement year. Report two age stratifications and an overall rate:</p> <ul style="list-style-type: none"> <li>■ 42-51</li> <li>■ 52-69</li> <li>■ Total.</li> </ul> <p><b>Note:</b> Given the measurement look-back period, women 40-69 will be captured in this measure.</p> <p><b>Medical Record Collection:</b> Women 42-69 years as of December 31 of the measurement year. Report two age stratifications and an overall rate:</p> <ul style="list-style-type: none"> <li>■ 42-51</li> <li>■ 52-69</li> <li>■ Total.</li> </ul> <p><b>Note:</b> Given the measurement look-back period, women 40-69 will be captured in this measure.</p> <p><b>Denominator (patients for inclusion):</b> A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective, or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p>	<p>Exclusions: Exclude women who had a bilateral mastectomy and for whom administrative data does not indicate that a mammogram was performed. Look for evidence of bilateral mastectomy as far back as possible in the patient's history, through either administrative data or medical record review (exclusionary evidence in the medical record must include a note indicating a bilateral mastectomy). If there is evidence of two separate mastectomies, this patient may be excluded from the measure. The bilateral mastectomy must have occurred by December 31 of the measurement year.</p> <p>Codes to identify exclusions for breast cancer screening: (for Bilateral: ICD-9-CM Codes: 85.42, 85.44-85.46, 85.48; CPT Codes: 19180, 19180.50 or 19180 w/ modifier 09950*, 19200, 50 or 19200 w/ modifier code 09950*, 19220, 50 or 19220 w/ modifier 09950, * 19240, 50 or 19240 w/ modifier 09950*). (For Unilateral codes (need two separate occurrences on two different dates of service): ICD-9-CM Codes: 85.41, 85.43, 85.45, 85.47; CPT Codes 19180, 19200, 19220, 19240).</p> <p>* .50 and 09950 modifier codes indicate the procedure was bilateral and performed during the same operative session.</p>	<p>Electronic data (i.e., claims or encounter data for visits, diagnoses and procedures) or medical record review.</p>

(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### PREVENTION, IMMUNIZATION, AND SCREENING - SCREENING (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CERVICAL CANCER SCREENING</b>	NQQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> One or more Pap tests during the measurement year or the two years prior to the measurement year. A woman had a Pap test if a submitted claim/encounter contains any one of the following codes:</p> <p>CPT: 88141-88145, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175; LOINC: 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0; ICD-9-CM: 91.46; V Codes: V72.32, V76.2; UB-92: 0923; HCPCS: G0101, G0123, G0124, G0141, G0143-60145, G0147, G0148, P3000, P3001, Q0091.</p> <p><b>Medical Record Collection:</b> Numerator: One or more Pap tests during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include both of the following:</p> <ul style="list-style-type: none"> <li>■ A note indicating the date the test was performed</li> <li>■ The result or finding.</li> </ul>	<p><b>Electronic Collection:</b> Women 24–64 years of age during the measurement year.</p> <p><i>Note:</i> Given the measurement look-back period, women 21-64 will be captured in this measure.</p> <p><b>Medical Record Collection:</b> Denominator: A systematic sample of women 24–64 years during the measurement year.</p> <p><i>Note:</i> Given the measurement look-back period, women 21-64 will be captured in this measure.</p> <p>Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Denominator (patients for inclusion):</b> A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective, or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p>	<p>Women who had a hysterectomy and who have no residual cervix and for whom the data do not indicate that a Pap test was performed. Look for evidence of a hysterectomy as far back as possible in the patient's history, through either administrative data or medical record review (exclusionary evidence in the medical record must include a note indicating a hysterectomy with no residual cervix). Documentation of "complete hysterectomy," "total hysterectomy," "total abdominal hysterectomy," or "radical hysterectomy" meets the criteria for hysterectomy with no residual cervix. Documentation of "hysterectomy" alone does not meet the criteria because it does not indicate the cervix has been removed).</p> <p>The hysterectomy must have occurred by December 31 of the measurement year. Use any of the following codes or descriptions of codes in the medical record listed below to identify allowable exclusions:</p> <p>Surgical codes for hysterectomy: CPT: 51925, 56308, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550, 58551, 58552-58554, 58951, 58953-58954, 58956, 59135; ICD-9-CM: 68.4-68.8, 618.5; V Codes: V67.01, V76.47.</p>	<p>Electronic data (i.e., claims or encounter data for visits, diagnoses laboratory and procedures) or medical record review.</p>

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - SCREENING (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CHLAMYDIA SCREENING IN WOMEN</b>	NCQA <sup>2,4</sup>	<p><b>Electronic Collection:</b> At least one Chlamydia test during the measurement year as documented through administrative data. A woman is considered as having a test if she had a claim/encounter with a service date during the measurement year with one or more of the following codes to identify Chlamydia screening: CPT: 87110, 87270, 87320, 87490, 87491, 87492, 87810</p> <p>LOINC: Chlamydia trachomatis tests: 4993-2, 6349-5, 6355-2, 6356-0, 6357-8, 14470-9, 14471-7, 14463-4, 14464-2, 14467-5, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 16602-5, 20993-2, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6.</p> <p>LOINC: 42931-6, 6349-5, 43406 Chlamydia species tests: 557-9, 560-3; LOINC: Chlamydia tracomatis and Neisseria gonorrhoeae tests: 36902-5, 36903-3.</p>	<p><b>Electronic Collection:</b> Women 16-25 years of age (reported in stratifications of 16-20, 21-25 and overall) as of December 31 of the measurement year who are sexually active. Two methods are provided to identify sexually active women:</p> <ul style="list-style-type: none"> <li>▪ Pharmacy data: Patients dispensed prescription contraceptives (oral contraceptives, IUD, diaphragm or other prescribed contraceptive) during the measurement year</li> <li>▪ Claims/encounter data: Patients who had at least one encounter during the measurement year with any of the diagnosis or procedure codes listed below.</li> </ul>	<p>Exclusions: Patients should be excluded who had a pregnancy test during the measurement year followed within seven days (inclusive) by either a prescription for Accutane (isotretinoin) or an x-ray. This exclusion does not apply to patients who qualify for the denominator based on services other than the pregnancy test alone. The following codes and descriptions of codes are provided to identify these services:</p> <p>Pregnancy test CPT: 81025, 84702, 84703 LOINC: 2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 19080-1, 19180-9, 20415-6, 20994-0, 21198-7, 25372-4, 25373-2, 34670-0</p> <p>CPT Codes: 11975-11977, 57022, 57170, 58300, 58301, 58600, 58605, 58611, 58615, 58970, 58974, 58976, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59200, 59300, 59320, 59325, 59350, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 59840, 59841, 59850-59852, 59855-59857, 59866, 59870, 59871, 59897, 59898, 59899, 76601, 76602, 76605, 76612, 76810-76812, 76815-76821, 76825-76828, 76941, 76945-76946, 80055, 81025, 82105, 82106, 82143, 82731, 83632, 83661-83664,</p>	<p>Electronic data (i.e., claims or encounter data for visits, diagnoses, laboratory, pharmacy, and procedures) or medical record review.</p>

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - SCREENING (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CHLAMYDIA SCREENING IN WOMEN</b> <i>continued</i>		<p>trachomatis or species test with a service date during the measurement year.</p> <p>Documentation in the medical record must include both of the following:</p> <ul style="list-style-type: none"> <li>■ A note indicating the date Chlamydia test was performed AND</li> <li>■ The result or finding.</li> </ul>	<p>84163, 84702-84703, 86592-86593, 86631-86632, 87110, 87164, 87166, 87220, 87320, 87490-87492, 87290-87292, 87620-87622, 87800, 87801, 87810, 87350, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175, 88235, 88267, 88269</p> <p>I01NC Codes: 42316-0, 42481-2, 42931-6, 43406-8 Pregnancy tests: 2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 19080-1, 19180-9, 20415-6, 20994-0, 21198-7, 25372-4, 25373-2, 34670-0</p> <p>Alpha-fetoprotein tests: 1832-5, 1834-1, 15019-3, 19171-8, 19176-7, 19177-5, 31993-9</p> <p>Fibronectin tests: 20403-2, 20404-0</p> <p>Syphilis tests: 660-1, 5291-0, 5292-8, 5392-6, 5333-4, 5394-2, 6561-5, 6562-3, 8041-6, 11084-1, 11597-2, 17723-8, 17724-6, 17725-3, 17726-1, 17727-9, 17728-7, 17729-5, 20507-0, 20508-8, 22461-8, 22462-6, 22587-0, 22590-4, 22592-0, 22594-6, 24110-9, 24312-1, 26009-1, 31147-2, 34382-2</p> <p>Chlamydia trachomatis tests: 4993-2, 63349-5, 63545, 6355-2, 63356-0, 63557-8, 14470-9, 14471-7, 14463-4, 14464-2, 14467-5, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 16602-5, 20993-2, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6</p> <p>Chlamydia species tests: 557-9, 560-3, Neisseria gonorrhoeae tests: 688-2, 690-8, 691-6, 692-4, 693-2, 698-1, 5028-6, 6487-3, 6488-1, 6489-9,</p>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - SCREENING (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CHLAMYDIA SCREENING IN WOMEN</b> <i>continued</i>			21414-8, 21415-5, 21416-3, 23908-7, 24111-7, 29311-8, 31905-3, 31906-1, 32198-4, 32199-2, 32205-6 Chlamydia trachomatis and Neisseria gonorrhoeae tests: 36902-5, 36903-3 HPI/tests: 6510-2, 6511-0, 6514-4, 6516-9, 7975-6, 10705-2, 11083-3, 11481-9, 12222-6, 12223-4, 14499-8, 14500-3, 14502-9, 14503-7, 14504-5, 14506-0, 16280-0, 17398-9, 17399-7, 17400-3, 17401-1, 17402-9, 17403-7, 17404-5, 17405-2, 17406-0, 17407-8, 17408-6, 17409-4, 17410-2, 17411-0, 17412-8, 21440-3, 21441-1, 30167-1, 38372-9 Pap tests: 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0 Amniotic fluid cytogenetics tests: 33773-3, 34493-7, 34656-9, 34718-7, 35457-1 Obstetric panel: 24364-2 ICD-9 Codes: 69.01, 69.51, 69.52, 69.7, 97.24, 97.91, 97.7372-75, 042, 054, 10, 054.11, 054.12, 054.19, 078.1, 078.88, 079.4, 079.51-079.53, 079.98, 079.98, 091.0-098.0, 098.10, 098.11, 098.15-098.19, 098.2, 098.30, 098.31, 098.35- 098.39, 098.4-099.9, 131, 614-616, 622.3, 623.4, 626.7, 628, 630-677, 795.0, 996.32 V Codes: V01.6, V02.7, V02.8, V08, V15, V722-V28, V45.5, V61.5, V61.6, V61.7, V72.3, V72.4, V74.5, V73.88, V73.98, V76.2 UB92 Revenue Codes: 0112, 0122, 0132, 0142, 0152, 0720-22, 0724, 0729, 923, 925	(more)	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - SCREENING (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CHLAMYDIA SCREENING IN WOMEN</b> <i>continued</i>			<p>HCPs; G0101, G0122, G0124, G0141, G0143-0145, G0147, G0148, H1000, H1003-1005, P3000, P3001, Q0091, S0199, S4981, S8055.</p> <p><b>Medical Record Collection:</b> EHR users may opt to use this methodology or the electronic data collection methodology described above. EHR users who have information on drugs prescribed and not dispensed may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Denominator:</b> A systematic sample of women 16-25 years of age (reported in stratifications of 16-20, 21-25 and overall) as of December 31 of the measurement year who are sexually active. Two methods are provided to identify sexually active women: prescriptions and diagnoses. Use both methods to identify the eligible population, although a patient must appear in only one method to be eligible for the measure.</p> <ul style="list-style-type: none"> <li>■ <b>Prescriptions:</b> Documentation of patients prescribed contraceptives (oral contraceptives, IUD, diaphragm or other prescribed contraceptive) during the measurement year</li> <li>■ <b>Diagnoses:</b> Documentation of patients who had at least one encounter during the measurement year with any of the diagnoses or procedures listed below: <ul style="list-style-type: none"> <li>● Pregnancy tests, alpha-fetoprotein tests, Fibrinogen tests, syphilis tests, Chlamydia trachomatis test, Chlamydia species tests, Neisseria gonorrhoeae tests, Chlamydia</li> </ul> </li> </ul>		(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - SCREENING (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CHLAMYDIA SCREENING IN WOMEN</b> <i>continued</i>			<p>trachomatis and <i>Neisseria gonorrhoeae</i> tests, HPV tests, Pap tests, amniotic fluid cytogenetics tests, obstetric panel.</p> <p><b>Denominator (patients for inclusion):</b> A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p>		<p>Electronic data (i.e., claims or encounter data for visits, diagnoses, laboratory, and procedures) or medical record review.</p>
<b>COLORECTAL CANCER SCREENING</b>	NQOAs <sup>2,4</sup>	<p><b>Electronic Collection:</b> One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the four criteria below:</p> <ul style="list-style-type: none"> <li>■ Fecal occult blood test (FOBT) during the measurement year</li> <li>■ Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year</li> <li>■ Double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year</li> <li>■ Colonoscopy during the measurement year or the nine years prior to the measurement year.</li> </ul>	<p><b>Administrative Data:</b> Patients 51–80 years of age during the measurement year. <i>Note:</i> Given the measurement look-back period, adults 50–80 will be captured in this measure.</p> <p><b>Medical Record Data:</b> EHR users may opt to use this methodology or the electronic data collection methodology described above. EHR users may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p><b>Denominator:</b> A systematic sample of patients 51–80 years of age during the measurement year. <i>Note:</i> Given the measurement look-back period, adults 50–80 will be captured in this measure.</p>	<p>Exclusions: Patients with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the patient's history, through either administrative data or medical record review. Exclusionary evidence in the medical record must include a note indicating a diagnosis of colorectal cancer or total colectomy, which must have occurred by December 31 of the measurement year. Use the following codes or descriptions of the codes to identify allowable exclusions:</p> <p>Malignant neoplasm of colon and other specified sites of colon and large intestine (more)</p>	

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - SCREENING (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>COLORECTAL CANCER SCREENING</b> <i>continued</i>		<p>A patient had an appropriate screening if a submitted claim/encounter contains any one of the following codes:</p> <ul style="list-style-type: none"> <li>■ Fecal occult blood test (FOBT) CPT Codes: 82270, 82274; LOINC: 2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3; HCPCS: G0107, G0328; ICD-9-CM V76.51</li> <li>■ flexible sigmoidoscopy CPT Codes 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345; HCPCS: G0104</li> <li>■ ICD-9-CM: 45.24, 45.42</li> <li>■ Double contrast barium enema (DCBE) CPT Code: 74280</li> <li>■ Colonoscopy CPT Codes: 44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392; HCPCS: G0105, G0121</li> <li>■ ICD-9-CM: 45.22, 45.23, 45.25, 45.43.</li> </ul> <p><b>Medical Record Collection:</b> Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.</p> <p>One or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the four criteria below:</p> <p>(more)</p>	ICD-9-CM Codes: 153.X, 154.0, 154.1, 197.5, V10.05 Total colectomy CPT Codes: 44150-44153, 44155-44156, 44210-44212; ICD-9-CM Codes: 45.8.		

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - SCREENING (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>COLORECTAL CANCER SCREENING</b> <i>continued</i>		<ul style="list-style-type: none"> <li>■ Fecal occult blood test (FOBT); both guaiac and immunochemical FOBT is acceptable) during the measurement year</li> <li>■ Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year</li> <li>■ Double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year. Air contrast enema is a clinical synonym</li> <li>■ Colonoscopy during the measurement year or the nine years prior to the measurement year.</li> </ul> <p>Documentation in the medical record must include both of the following:</p> <ul style="list-style-type: none"> <li>■ A note indicating the date the colorectal cancer screening was performed</li> <li>■ For a notation in the progress notes, the result or finding (this ensures the screening was performed and not merely ordered).</li> </ul> <p>For a notation in the medical history, a result is not required. Documentation in the medical history pertains to screenings that occurred in the past, and it is assumed that the result was negative (a positive result would have been noted as such). A notation in the medical history must include a date reference that meets the timeline outlined in the specifications.</p>			(more)

## Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)

### PREVENTION, IMMUNIZATION, AND SCREENING - SCREENING (continued)

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>FALL RISK MANAGEMENT IN OLDER ADULTS</b>	NCQA <sup>2,4</sup>	<p><b>Numerator a:</b> Discussing fall risk: The number of patients in the denominator who responded "yes" to the question, "A fall is when your body goes to the ground without being pushed. In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?" — Q1</p> <p><b>Numerator b:</b> Managing fall risk: The number of patients in the denominator b who responded "yes" to the question, "Has your doctor or other health provider done these or anything else to help prevent falls or treat problems with balance or walking?" Some examples of things they might do include:</p> <ul style="list-style-type: none"> <li>■ Suggest that you use a cane or walker</li> <li>■ Check your BP lying or standing</li> <li>■ Suggest that you do an exercise or physical therapy program</li> <li>■ Suggest a vision or hearing testing.</li> </ul>	<p><b>Denominator a:</b> Discussing fall risk: All patients 75 years and older as of December 31 of the measurement year, AND patients 65 years to 74 years as of December 31 of the measurement year who responded "yes" to either of the questions, "Did you fall in the past 12 months?" — Q2 OR "yes" to the question, "In the past 12 months, have you had problems with balance or walking?" — Q3 AND who indicated they were seen by a provider during the measurement year.</p> <p><b>Denominator b:</b> Managing fall risk: Patients 65 years and older as of December 31 of the measurement year who responded "yes" to either of the questions, "Did you fall in the past 12 months?" — Q2 OR "yes" to the question, "In the past 12 months, have you had problems with balance or walking?" — Q3 AND who indicated they were seen by a provider during the measurement year.</p>	None.	Patient survey.
<b>OSTEOPOROSIS TESTING IN OLDER WOMEN</b>	NCQA <sup>2,4</sup>	<p><b>Numerator:</b> The number of patients in the denominator who responded "yes" to the question, "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'? This test may have been done to your back, hip, wrist, heel, or finger."</p>	<p><b>Denominator:</b> Women 65 and older as of December 31 of the measurement year who answered "yes" or "no" to the question, "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'? This test may have been done to your back, hip, wrist, heel, or finger."</p>	None.	Patient survey.
					(more)

## APPENDIX A – SPECIFICATIONS OF THE NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR AMBULATORY CARE—PART 1 (CONTINUED)

### PREVENTION, IMMUNIZATION, AND SCREENING - IMMUNIZATION

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CHILDHOOD IMMUNIZATION STATUS</b>	NCQA <sup>2,4</sup>	<p>Electronic Collection: For all antigens, count any of the following:</p> <ul style="list-style-type: none"> <li>■ evidence of the antigen, or documented history of the illness, or a seropositive test result.</li> </ul> <p>For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), find evidence of all of the antigens.</p> <p>DTaP/DT: An initial DTaP vaccination followed by at least three DTaP/DT, or individual diphtheria and tetanus shots on or before the child's second birthday. Any vaccination administered prior to 42 days after birth cannot be counted. In states where the law allows an exception to a child who receives a pertussis vaccination, the child is compliant if he or she has four diphtheria and four tetanus vaccinations</p> <p>IPV: At least three polio vaccinations (IPV) with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth cannot be counted</p> <p>MMR: At least one measles, mumps, and rubella (MMR) vaccination, with a date of service falling on or between the child's second birthday</p> <p>HiB: Three Hi influenza type B (HiB) vaccinations, with different dates of service on or before the child's second birthday. HiB administered prior to 42 days after birth cannot be counted</p> <p>Note: Because use of one particular type of HiB vaccine requires only three doses, the measure requires meeting the minimum possible standard</p>	<p><b>Electronic Collection:</b> Children who turn two years of age during the measurement year.</p> <p><b>Medical Record Collection:</b> Denominator: A systematic sample drawn from children who turn two years of age during the measurement year.</p> <p><b>Denominator (patients for inclusion):</b> A sample should be determined using the most accurate data available in the settings in which the measure will be implemented. The measure developer recommends that in most settings office visit claims (see list of codes) or other codified encounter data should be used to identify patients who have had at least one office visit in the prior (12) months from which a purposeful sample (random, consecutive retrospective or prospective from a specific date) can then be chosen for the denominator. In other uses of the measure, insurer level claims (pooled or single insurer) data can be used to identify the denominator.</p>	<p>Exclusions: Children who had a contraindication for a specific vaccine should be excluded from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. In excluding contraindicated children, this may only be done for those children where the administrative data does not indicate that the contraindicated immunization was rendered. The exclusion must have occurred by the patient's second birthday. Contraindications should be looked for as far back as possible in the patient's history. The following may be used to identify allowable exclusions:</p> <p>Immunization: Any particular vaccine</p> <p>Contraindication: Anaphylactic reaction to the vaccine or its components (ICD-9: 999.4</p> <p>Immunization: DTaP</p> <p>Contraindication: Encephalopathy ICD-9: 323.5 (must include E948.4 or E948.5 or E948.6 to identify the vaccine)</p> <p>Immunization: VZV and MMR</p> <p>Contraindication: Immunodeficiency, including genetic (congenital) immunodeficiency syndromes (ICD-9: 279</p> <p>Immunization: VZV and MMR</p> <p>Contraindication: HIV-infected or household contact with HIV infection (ICD-9: infection V08, symptomatic 042</p>	<p>NCQA</p> <p>(more)</p>

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - IMMUNIZATION (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CHILDHOOD IMMUNIZATION STATUS</b> <i>continued</i>		<p>of three doses, rather than the recommended four doses</p> <p>Hepatitis B: Three hepatitis B vaccinations, with different dates of service on or before the child's second birthday</p> <p>VZV: At least one chicken pox vaccination (VZV), with a date of service falling on or between the child's first and second birthdays</p> <p>Pneumococcal conjugate: At least four pneumococcal conjugate vaccinations on or before the child's second birthday</p> <p>Combination 2 (DTaP/IPV/MMR, HiB, hepatitis B, VZV): Children who received four DTaP/DT vaccinations; three IPV vaccinations; one MMR vaccination; three HiB vaccinations; three hepatitis B; and one VZV vaccination</p> <p>Combination 3 (DTaP/IPV/MMR, HiB, hepatitis B, VZV, pneumococcal conjugate): Children who received all of the antigens listed in Combination 2 and four pneumococcal conjugate vaccinations</p> <p>DTaP: CPT: 90698, 90700, 90721, 90723; ICD-9: 99.39</p> <p>Diphtheria and tetanus: CPT: 90702</p> <p>Diphtheria: CPT: 90719; ICD-9-V02.4, * 032, * 99.36</p> <p>Tetanus: CPT: 90703; ICD-9: 037, * 99.38</p> <p>Pertussis: ICD-9-033, * 99.37</p> <p>IPV: CPT: 90698, 90713, 90723; ICD-9-V12.02, 045, * 99.41, 138</p> <p>MMR: CPT: 90707, 90710; ICD-9-99.48</p> <p>Measles: CPT: 90705, 90708; ICD-9: 055, * 99.45</p>		<p>Immunization: VZV and MMR</p> <p>Contraindication: Cancer of lymphoreticular or histiocytic tissue: ICD-9: 200-202</p> <p>Immunization: VZV and MMR</p> <p>Contraindication: Multiple myeloma: ICD-9: 203</p> <p>Immunization: VZV and MMR</p> <p>Contraindication: Leukemia: ICD-9: 204-208</p> <p>Immunization: IPV contraindication: Anaphylactic reaction to streptomycin, polymyxin B or neomycin</p> <p>Immunization: HiB contraindication: None</p> <p>Immunization: Hepatitis B</p> <p>Contraindication: Anaphylactic reaction to common baker's yeast</p> <p>Immunization: VZV and MMR</p> <p>Contraindication: Anaphylactic reaction to neomycin</p> <p>Immunization: Pneumococcal conjugate</p> <p>Contraindication: None.</p>	(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - IMMUNIZATION (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CHILDHOOD IMMUNIZATION STATUS</b> <i>continued</i>		Mumps: CPT:90704,90709; ICD-9:072,* 99.46 Rubella: CPT:90706,90708,90709; ICD-9:056,* 99.47 Hib: CPT:90645,90646,90647,90648,90698, 90720,90721,90748; ICD-9:041.5,* 038.41.* 330.0,* 482.2* Hepatitis B*: CPT:90723,90740,90744,90747, 90748; ICD-9:V02.61,* 070.2,* 070.3*; HCPCS: G0010, Q3021, Q3023 VZV: CPT:90710,90716; ICD-9:052,* 053* Pneumococcal conjugate: CPT:90669; HCPCS: G0009.			

\*Indicates evidence of the disease. A patient who has evidence of the disease during the numerator event time is compliant for the antigen.

**Medical Record Collection:** Electronic Health Record (EHR) users may opt to use this methodology or the electronic data collection methodology described above. EHR users may opt to follow the medical record specifications below but produce data on 100% of their denominator population instead of a sample.

**Numerator:** For all antigens, count any of the following:

- Evidence of the antigen or combination vaccine,  
OR
- Documented history of the illness  
OR
- A seropositive test result.

(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - IMMUNIZATION (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>CHILDHOOD IMMUNIZATION STATUS</b> <i>continued</i>		<p>For combination vaccinations that require more than one antigen (i.e., MMR), find evidence of all of the antigens. For immunization information obtained from the medical record, count patients where there is evidence that the antigen was rendered from:</p> <ul style="list-style-type: none"> <li>■ A note indicating the name of the specific antigen and the date of the immunization</li> </ul> <p>Or</p> <ul style="list-style-type: none"> <li>■ A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.</li> </ul> <p>For documented history of illness or a seropositive test result, find a note indicating the date of the event. The event must have occurred by the patient's second birthday.</p> <p>Notes in the medical record indicating that the patient received the immunization "at delivery" or "in the hospital" may be counted toward the numerator. This applies only to immunizations that do not have minimum age restrictions (e.g., prior to 42 days after birth). A note that the "patient is up-to-date" with all immunizations that does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for this measure.</p>			(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - IMMUNIZATION (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>FLU SHOTS FOR ADULTS AGES 50 TO 64</b>	NCQA <sup>2,4</sup>	The number of patients in the denominator who responded, "Yes" to the question "Have you had a flu shot since September 1, YYYY?"	The number of patients 50-64 years who responded "Yes" or "No" to the question "Have you had a flu shot since September 1, YYYY?"	No exclusions listed.	Patient survey.
<b>FLU SHOTS FOR OLDER ADULTS</b>	NCQA <sup>2,4</sup>	The number of patients in the denominator who responded "Yes" to the question, "Have you had a flu shot since September 1, YYYY?"	The number of patients 65 years or older who responded "Yes" or "No" to the question, "Have you had a flu shot since September 1, YYYY?"	None.	Patient survey.
<b>INFLUENZA IMMUNIZATION</b>	AMA PCP <sup>2,3</sup>	<p>Patients who received influenza vaccination from September through February of the year prior to the measurement period.</p> <p>ICD-9-CM Codes for need vaccine: V04.81</p> <p>OR</p> <p>CPT Procedure Codes for adult influenza vaccine:</p> <p>90656, 90658, 90660</p> <p>OR</p> <p>CPT II Code 4037F-Influenza immunization ordered or administered</p> <p>OR</p> <p>HPCPS Code: G0008</p> <p>OR</p> <p>Medical record includes documentation of patient report of having received the vaccination.</p>	<p>All patients <math>\geq 50</math> years of age at the beginning of the one-year measurement period.</p> <p>Patient selection: CPT Codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99386-99387, 99396-99397, 99401-99404, 90471-90474</p> <p>AND</p> <p>Patient's age is <math>\geq 50</math> years at the beginning of the one-year measurement period.</p> <p>OR</p> <p>Adverse reaction to influenza vaccine: 995.0 and E949.6, 995.1 and E949.6, 995.2 and E949.6</p> <p>OR</p> <p>Documentation of patient reason(s) (e.g., economic, social, religious) for not receiving an influenza vaccination: CPT II Code w/modifier: 4037F2P</p> <p>OR</p> <p>Documentation of system reason(s) for not administering an influenza vaccination (e.g., vaccine shortage): CPT II Code w/modifier: 4037F3P</p>	<p>EHRs, paper medical records, administrative data using CPT II Codes or prospective flowsheet.</p> <p>OR</p> <p>Egg allergy: ICD-9 CM Codes: 693.1, V15.03, 995.68</p> <p>OR</p> <p>Documentation of patient reason(s) (e.g., economic, social, religious) for not receiving an influenza vaccination: CPT II Code w/modifier: 4037F2P</p> <p>OR</p> <p>Documentation of system reason(s) for not administering an influenza vaccination (e.g., vaccine shortage): CPT II Code w/modifier: 4037F3P.</p>	(more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - IMMUNIZATION (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
<b>PNEUMOCOCCAL VACCINE NEEDED FOR ALL ADULTS AGED 65 YEARS OR OLDER</b>	RHI	Adults aged 65 to 67 years who have not received a pneumococcal vaccine. Pneumococcal Vac Polyvalent CPT Codes: 90471 Immunization Admin 90472 Immunization Admin, Each Add 90732 Pneumococcal Vaccine HCPCS: G0009 Admin Pneumococcal Vaccine	Adults aged 65 to 67.	Inclusion criteria: Patients must be between 65 and 67 years old and eligible to receive services during the past two years. Exclusion criteria: None (Claims data does not currently include clinical information).	This measure uses data from one or more health plans to derive information at the physician level. Set of procedure codes (e.g., CPT, HCPCS) for an influenza vaccine. Only the presence or absence of the relevant codes is evaluated.  Administrative medical (inpatient and outpatient) and pharmacy claims data.  Eligibility data from health plan.  At least two years of historical claims data are requested.
<b>PNEUMONIA VACCINATION STATUS FOR OLDER ADULTS</b>	NQCA <sup>24</sup>	The number of patients in the denominator who responded "Yes" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."	The number of patients 65 years and older as of January 1 of the measurement year who responded, "Yes" or "No" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."	None given.	Patient survey.  (more)

**Appendix A – Specifications of the National Voluntary Consensus Standards for Ambulatory Care—Part 1 (continued)**

**PREVENTION, IMMUNIZATION, AND SCREENING - IMMUNIZATION (continued)**

Measure	IP Owner <sup>1</sup>	Numerator	Denominator	Exclusions	Data Source
PNEUMONIA VACCINATION	CMS/NQQA <sup>2,4</sup>	Patients who have ever received a pneumococcal vaccination: CPT Procedure Code for adult pneumococcal vaccination: 90732; HCPCS Code: G0009.	All patients ≥65 years of age in the measurement year.	<p>Exclusions:</p> <ul style="list-style-type: none"> <li>■ Previous anaphylactic reaction to the vaccine or any of its components</li> <li>■ Other medical reason(s) documented by the practitioner for not receiving a pneumococcal vaccination: ICD-9-CM Exclusion Codes for PC-8 Pneumonia Vaccination: 995.0 and E949.6, 995.1 and E949.6, 995.2 and E949.6</li> <li>■ Patient reason(s) (e.g., economic, social, religious).</li> </ul>	Paper medical record, flowsheet, EHRS.